U.S. DEPARTMENT OF

HEALTH AND HUMAN SERVICES

Washington, D.C.

THE FISCAL YEAR 1997 BUDGET

The attached document is based on the President's Budget scheduled for delivery to the Congress on March 19, 1996, and is strictly embargoed until 11:00 a.m. that day.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FY 1997 BUDGET

TABLE OF CONTENTS

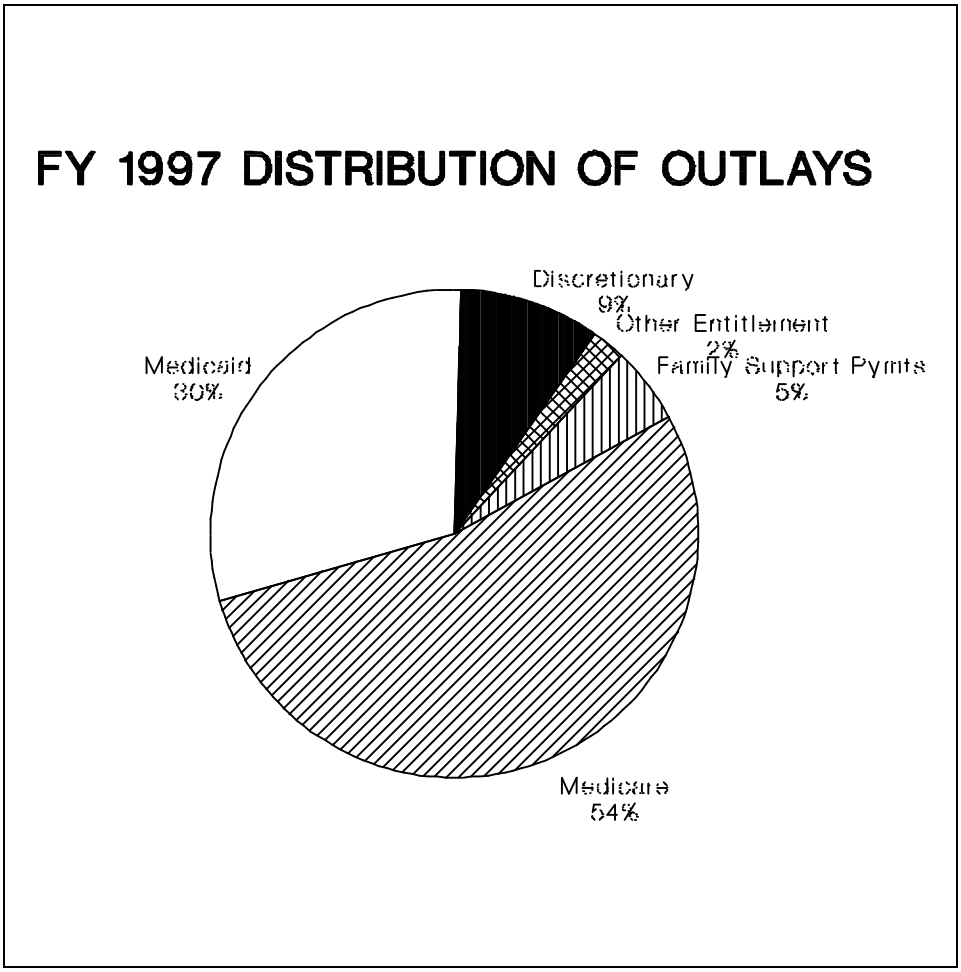
SUMMARY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Budget Authority/Income	$302,150	$317,258	$354,695	$37,437
Outlays.....	$303,107	$327,463	$354,126	$26,663

* Based on levels of the ninth CR, including an incremental policy adjustment.



CREATING OPPORTUNITIES WHILE ENCOURAGING RESPONSIBILITY

The FY 1997 Budget proposes a balanced budget by FY 2002 through a combination of savings, responsible reforms, and good management. In so doing, the budget preserves our core values of protecting our most vulnerable Americans, especially senior citizens, people with disabilities, working families and children.

The FY 1997 Budget for the Department of Health and Human Services (HHS), totals $354 billion in outlays, an increase of $27 billion, or 8 percent, over the comparable FY 1996 amount. The discretionary portion of the HHS budget totals $34 billion in budget authority, an increase of 5 percent over the FY 1996 policy level. The FY 1996 policy level is based on levels of the ninth continuing resolution, including an incremental policy adjustment.

HHS is a major part of the President's effort to realize a seven-year balanced budget through the combination of welfare reform and revision of the Medicare and Medicaid programs. Reform of these entitlement programs is a substantial part of the savings in the President's plan.

The President's Medicare plan strengthens and improves the program, reducing spending by a net $124 billion over seven years and guaranteeing the solvency of the hospital insurance trust fund for more than a decade. Specific reforms give seniors more choices among private health plans, make Medicare more efficient and responsive to beneficiary needs, attack fraud and abuse through programs praised by law enforcement officials, cut the growth rate of provider payments, and hold the Part B premium at 25 percent of program costs.

Comprehensive welfare reform is a key component of our effort to promote self-reliant and stable families. The President has been working to make welfare a second chance rather than a way of life and is committed to signing a welfare bill that succeeds in moving people from welfare to work. Real welfare reform must emphasize work, responsibility, and family--imposing time limits, tough work requirements, and high standards upon parents to take responsibility for themselves and their children. Children should be protected and families must get the child care they need to go to work.

The President's FY 1997 Budget includes a major proposal to replace the Aid to Families with Dependent Children program with a time-limited conditional entitlement. This proposal would also increase funding for child care programs and improve child support enforcement measures. The Administration supports rewarding States while holding them accountable for their efforts to put people to work, not for simply cutting families off of welfare assistance. States would have the flexibility to design welfare programs which would meet the needs of their communities. This plan would save a projected $40 billion over seven years. With the

support of Congress, we will enact changes to encourage parental responsibility, promote economic security, and protect families.

In addition to these reforms, HHS remains committed to a path of tough management and strategic investment in priority areas. The FY 1997 HHS Budget continues to promote health and science by increasing funding in key areas such as the National Institutes of Health, Ryan White AIDS Treatment grants, substance abuse and mental health treatment, and heightening our vigilance against emerging infectious diseases. The FY 1997 Budget also invests in Head Start, the Child Care and Development Block Grant, and a new Teen Pregnancy Prevention initiative.

STRENGTHENING MEDICARE AND MEDICAID

Medicare Improvements that Expand Choices and Add Preventive Benefits

The President's plan for improving choice in Medicare refines and enhances standards, increases the options available to Medicare beneficiaries, and expands the types of organizations offering Medicare products. It will improve Medicare's health plan payment coverage, foster continuous improvements in health plan quality, help beneficiaries become more informed about their choices, and level the playing field for Medicare managed care and Medicare supplemental coverage. Other changes begin the transformation of the traditional fee-for-service program from a bill-paying insurance program into a responsive health plan by giving Medicare authority to adopt many of the purchasing and quality techniques pioneered by private sector payors.

The budget also expands and improves Medicare managed care by:

- ensuring beneficiary protections while increasing the types of plans--including Preferred Provider Organizations (PPOs) and Provider Sponsored Networks (PSNs)--available to seniors; and

- instituting a coordinated open enrollment process--similar to that used by the Federal Employees Health Benefits Plan (FEHBP)--during which beneficiaries use comparative information to choose among managed care and supplemental insurance options.

In addition, the budget expands coverage of preventive benefits to include annual mammograms and the elimination of mammography coinsurance, colorectal cancer screening, and increased payments for flu shots. Finally, the budget introduces a respite care benefit to provide some relief for families caring for relatives with Alzheimer's disease.

Survey and Certification

Ensuring the safety and quality of care provided by health facilities is one of HHS' most critical responsibilities. HHS contracts with State agencies to inspect health facilities providing services to Medicare and Medicaid beneficiaries to ensure compliance with Federal

health, safety, and program standards. Quality oversight efforts include initial inspections of providers who request participation in the Medicare program, annual recertification inspections of nursing homes and home health agencies (HHAs) as required by law, investigation into all long-term care facility complaints, and periodic recertification of other health care providers and suppliers.

In FY 1997, we are requesting a total of $173.8 million for direct survey and certification activities and workloads. We expect to survey more than 31,000 facilities in FY 1997. This $28 million increase over the FY 1996 policy level is necessary both to conduct initial inspections of more than 3,200 facilities expected to request Medicare participation (including the elimination of any prior year backlog), and to increase the frequency of annual surveys performed on non-long-term care facilities (e.g., End Stage Renal Disease facilities, hospices, rural health clinics). Congress did not fund the full FY 1996 President's request of $162.1 million for this activity, appropriating $145.8 million instead.

Medicaid Reform that Guarantees Coverage and Promotes State Flexibility

The Administration is committed to Medicaid reform guided by the following principles:

- preserve the guarantee of coverage with meaningful benefits for the most vulnerable Americans;
- maintain a strong Federal/State partnership;
- enhance State flexibility while ensuring protection for beneficiaries and accountability to taxpayers.

The President's plan for Medicaid reforms the program and preserves the guarantee of health and long-term care coverage for the most vulnerable Americans. It saves $59 billion over seven years responsibly, by limiting spending on a per-person basis (a "per capita cap") and reducing Disproportionate Share Hospital payments and retargeting them to hospitals that serve large numbers of Medicaid and uninsured patients.

The plan provides special payments for States to transition into the new system, and to meet the most pressing needs. It also gives States unprecedented new flexibility to administer their programs more efficiently. Finally, this plan retains current nursing home quality standards and continues to protect the spouses and other family members of nursing home residents from impoverishment.

Maintaining and Expanding Coverage for Working Americans

The Administration's FY 1997 Budget contains several provisions to make health coverage more accessible and affordable for working Americans.

- The President's insurance market reforms will enable more Americans to maintain health insurance coverage when they change jobs and will stop insurance companies from denying coverage for pre-existing conditions.

- To put the self-employed on a more equal footing with other businesses, the reforms gradually raise the self-employed tax deduction from 30 percent to 50 percent.

- To give small businesses the purchasing clout that larger businesses have, the budget proposes $25 million a year in grants that States can use for technical assistance and for setting up voluntary purchasing cooperatives.

- The President also proposes a four-year demonstration program to provide annual grants to States to provide health insurance for temporarily unemployed workers and their families. Under the program, States could provide up to six months of coverage for eligible workers and their families.

RESTORING TRUST AND UTILIZING INNOVATIVE APPROACHES TO MANAGEMENT

Program Integrity

As responsible managers of the public's money, the Secretary has made the integrity of Medicare and Medicaid a primary objective for the department. In FY 1997, the Federal Government will spend nearly $316 billion to purchase health care services for 72 million low-income, elderly, and disabled persons through these programs. Unfortunately, the large sums of money in Medicare and Medicaid have made them prime targets for those who would steal, take advantage of loopholes, and otherwise mismanage program funds. Increasingly sophisticated schemes are siphoning taxpayer dollars and robbing beneficiaries of their health care security. Responding to this epidemic, the HHS Inspector General (IG), together with the Health Care Financing Administration (HCFA), and the Administration on Aging (AoA) launched a major effort in FY 1995 to attack fraud and abuse in Medicare and Medicaid. Entering into a partnership with State Medicaid Fraud Control Units (MFCU), the Department of Justice, the Federal Bureau of Investigation and other State and local law enforcement officials, HHS initiated a five-state anti-fraud and abuse demonstration as part of the Vice President's Reinventing Government, Phase II. This two-year demonstration, "Operation Restore Trust," is currently operating in New York, Illinois, Florida, Texas, and California and focuses on curbing fraud, waste and abuse in providing three of the fastest growing Medicare services: nursing facilities, home health, and durable medical equipment.

In FY 1997, we are seeking permanent legislation to expand Operation Restore Trust to all States and Medicare services. We will continue to work with MFCUs and law enforcement agencies to ensure that claims are properly paid in both Medicare and Medicaid. To achieve our objectives, two new HHS programs, along with new initiatives in the Department of Justice, designed specifically to fight health care fraud and abuse are proposed: the Medicare Anti-fraud and Abuse Program (MAAP) in the Office of the HHS Inspector General and the Medicare Benefit Integrity System (MBIS) in the Health Care Financing Administration.

These new mandatory programs will provide secure and dependable funding for anti-fraud and abuse efforts.

We are proposing $97 million for MAAP in FY 1997, an increase of $54 million over FY 1996 estimated Medicare-related IG spending. MAAP will expand current efforts in the HHS Office of Inspector General (IG) to identify and investigate cases of fraud and abuse in Medicare. Working closely with the FBI and the Department of Justice, the IG will help to ensure that program defrauders are brought to trial. As a result of the intensified efforts, the IG will identify problems and recommend corrective actions that may be taken by HCFA, State Medicaid agencies and Medicare contractors.

MBIS is proposed to be funded at $500 million in FY 1997, an increase of $104 million over current spending levels. This program will replace current Medicare payment safeguards activity. MBIS will emphasize front-end review of Medicare claims to ensure appropriateness of care, to determine if other parties are liable for payment, and that claims are paid right the first time. With MBIS, we will redesign and upgrade program operations and data systems to close the door on defrauders and abusers before they can take advantage of the program and its beneficiaries.

Right-Sizing the HHS Workforce

Through its Reinventing Government initiative, this Administration is creating a government that works better and costs less. As part of this effort, we are rethinking our business at HHS, making sure that our programs work well and achieve their intended results.

We have committed ourselves to a seven-year right-sizing effort which will reduce the department's personnel by 7,000 FTE by the year 2000, bringing HHS in line with the President's plan to shrink the size of government. Using a combination of early-outs, selective hiring freezes and buy-outs, we reduced HHS staffing by nearly 3,300 FTE, or 5 percent, between FY 1994 and FY 1995, making a substantial down payment on our plan to right-size HHS. Staffing levels will remain at FY 1995 levels through both FY 1996 and FY 1997, and then decline by 2,500 FTE in the following three years.

Innovative Approaches to Management

In March 1995, the Social Security Administration (SSA) became an independent agency with approximately 50 percent of HHS staff transferring to this new independent agency. This transition was handled smoothly and in a timely manner with minimal personnel disruption. The end-product was two viable organizations. This was accomplished through the use of careful planning and is a significant accomplishment by HHS and SSA.

Pursuant to the Vice President's Reinventing Government program, we closely examined and made changes to the remaining organizations within HHS. An entire management layer was eliminated by consolidating the Office of the Assistant Secretary for Health (OASH) into Departmental Management (DM). This consolidation creates a unified corporate headquarters

for the Department that brings expertise in public health and science closer to the Secretary.

This merger and reconfiguration creates a new role for the Assistant Secretary for Health (ASH) who becomes the head of the Office of Public Health and Science (OPHS). The ASH will act as senior advisor for public health and science to the Secretary and provide senior professional leadership in the Department on population-based public health and clinical preventive services. The ASH also directs program offices within the OPHS; provides professional leadership on cross-cutting Departmental public health and science initiatives; and at the direction of the Secretary provides assistance in managing the implementation of Secretarial decisions for the PHS operating divisions. All Public Health Service Operating Divisions (OPDIVs) now report directly to the Secretary. The OPDIVs, along with the new OPHS and the Regional Health Administrators, continue to constitute the U.S. Public Health Service, with the Secretary at its head.

We have also merged the operations of the Assistant Secretary for Management and Budget with the Assistant Secretary for Personnel Management. The final result of these reorganizations is a smaller, more focused Office of the Secretary.

Finally, in the wake of SSA's departure and the DM/OASH merger, the Program Support Center (PSC) was created in FY 1996 as a new self-supporting operating division whose sole purpose is the provision of a broad range of administrative services. As the first true business enterprise at HHS, the PSC will provide services on a competitive, fee-for-service basis to customers throughout HHS and to other Federal agencies. This market based approach provides incentives for customers to reduce their costs by decreasing demands for service, and for providers to reduce their costs to remain competitive. The goal of the PSC is to further streamline and minimize duplication of functions in the provision of cost-effective services.

The financing for the PSC has also been streamlined. All activities of the OS Working Capital Fund will be merged into the Service and Supply Fund (SSF) in FY 1997. A new SSF charter has been approved, establishing a new Board of Directors chaired by the Deputy Secretary, with the Assistant Secretary for Management and Budget as the vice-chair. This governing body, designed to provide customer involvement on cost and service levels, includes representatives from each HHS Operating Division, the chief management officers of the PSC, and the Inspector General's Office.

BUILDING STRONG FOUNDATIONS AND SAFE PASSAGES

Today's young people are tomorrow's leaders. They will guide our democracy in the 21st century and, therefore, must be prepared to accept the challenges they will face. In order to ensure a positive future for our Nation's children, we need to work together to promote their healthy growth and development and to create safe, stable families in economically secure communities. The Department is committed to this goal and has developed a multifaceted strategy to promote strong futures for all children and youth. This strategy includes investing in Strong Foundations--the building blocks of success for children and

families, and Safe Passages--the tools for navigating the often turbulent journey from childhood to adulthood.

Head Start

A child's physical and mental well-being is dependent upon a strong foundation. Head Start programs help to establish that foundation for many disadvantaged children and families by providing comprehensive education, nutrition, health services and social services. In FY 1997, we are committed to expanding enrollment and making that opportunity available to more children. A budget increase of $350 million over the FY 1996 policy level will allow us to serve an additional 40,000 children. As part of this increase, an additional 1,200 infants and toddlers will be able to participate in the Department's Early Head Start program. This request will also allow us to continue making important quality improvements to local Head Start programs to ensure that children and families receive the highest quality services possible. Head Start is just one of the many programs funded by HHS which builds strong foundations, laying the groundwork for the critical journey through adolescence.

Child Care and Development Block Grant/Child Welfare

The availability of quality child care for low-income families is critical to maintain economic self-sufficiency and to promote healthy child development. The FY 1997 Budget request for the Child Care and Development Block Grant (CCDBG) is $1.049 billion. Over 750,000 children currently receive services. CCDBG also supports activities to improve the quality and availability of child care across the nation.

In addition, in FY 1997, the budget includes $419 million in discretionary funding for a range of programs that help States and local communities to protect children by strengthening families and preventing abuse; intervening when families are in crisis; and when necessary, making placement decisions to ensure children’s safety. In 1993, States received reports on nearly three million children who were alleged victims of child abuse and neglect, reflecting a 25 percent increase in the rate of children reported since 1988.

Teen Pregnancy Prevention

Teen pregnancy is a serious social problem for our Nation. Not only do we spend scarce health and welfare dollars to assist families begun by teenagers, but our Nation also suffers as we fail to realize the full potential of many of these teens and their children. In an effort to address this problem, the Department will launch a $30 million Teen Pregnancy Prevention Initiative in FY 1997. These funds will be used to implement and evaluate promising prevention strategies in communities which have demonstrated a commitment to community problem solving. This initiative is an important step forward to ensure safe passages for our Nation's adolescents.

PROMOTING HEALTH AND SCIENCE

National Institutes of Health - Biomedical/Behavioral Research

The FY 1997 Budget continues the Administration's high-priority investment in biomedical and behavioral research to secure the long-term health of Americans. The proposed $12.4 billion for NIH is a $467 million, or 4 percent, increase over FY 1996. NIH is devoted to expanding fundamental knowledge about living systems and the causes of disease, and to applying that knowledge to improve the health of human beings. Chief among NIH's mechanisms to accomplish this are investigator-initiated research project grants which receive an increase of $166 million and fund 6,827 new and competing research grants and a record 25,400 total grants in FY 1997.

The other prominent part of the FY 1997 Budget request for NIH is the revitalization of the operations and facilities of the Warren G. Magnuson Clinical Center. The request includes a total of $310 million to build a new state-of-the-art Clinical Center with replacement hospital and laboratories for the more than 40-year-old Clinical Center on the NIH campus. Furthermore, the FY 1997 Budget requests all of NIH's AIDS-related funds--$1.4 billion--in a single consolidated account for the Office of AIDS Research to ensure a coordinated and flexible response to the AIDS epidemic.

Ryan White

The FY 1997 request of $807 million for the Health Resources and Services Administration's Ryan White AIDS treatment activities, a $32 million increase over the FY 1996 policy level, continues our commitment to improve the quality and availability of care for individuals and families with HIV and AIDS. Funds will be used to expand activities in all four program areas including Emergency Relief for Cities, improve services for underserved and hard to reach populations, and support primary care services for an additional five to ten thousand individuals who are infected with, or at-risk of, HIV infection. The Administration is also proposing a $52 million budget amendment in FY 1996 to help states improve access to new promising HIV therapies, including protease inhibitors, a new class of AIDS drugs which are beginning to be approved by the Food and Drug Administration.

Providing Health Care to Native Americans

The FY 1997 President's Budget demonstrates our ongoing commitment to improving the health of American Indians and Alaska Natives and also in assisting those tribes who wish to take over the operation of their local health programs from the Indian Health Service. An increase of $43 million is requested to provide water and waste disposal service to existing Indian homes. The provision of such services, the top priority of the National Indian Health Board, is critical in reducing incidents of waterborne and other communicable diseases, gastroenteric disease, and neonatal death rates. Increased funding (+$16 million) is also requested for new health initiatives for women, children, elders, and urban Indians. The

President's Budget contains an additional $46 million to cover the contract support costs incurred by tribes in their operation of local programs.

Substance Abuse and Mental Health

In light of recent trends in drug use and mental illness in the country, the President's Budget also proposes an increase of $244 million to treat and prevent mental illness and substance abuse. An expanded knowledge development and application program will provide critically needed information about managed care; early childhood problems; individuals with, or at risk for, both mental health and substance abuse problems; services in the criminal justice system; and application of knowledge to improve service delivery systems at the local and State levels. The budget also proposes $1.5 billion for both the Substance Abuse and Mental Health Performance Partnership State grants.

New and Emerging Infectious Diseases

Emerging infectious disease outbreaks pose a threat to everyone in the country. Our vulnerability to waterborne, foodborne, and airborne infections has been dramatically demonstrated and widely publicized with recent disease outbreaks caused by *Cryptosporidium* parasites in the water supply in Milwaukee; *E. coli 0157:H7* bacteria in undercooked hamburgers in the Pacific Northwest; and hantavirus from rodents in the Southwest. The request includes an increase of $26 million, or a total of $45 million, to double our investment in the Centers for Disease Control and Prevention national prevention strategy--"Addressing Emerging Infectious Disease Threats." This investment will facilitate rapid identification and investigation of infectious disease outbreaks, reduce the burden of illness due to infections, and reduce associated health care costs.

HHS BUDGET BY OPERATING DIVISION

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Food and Drug Administration				
BA	$882	$878	$878	$0
Outlays	860	877	881	4
Health Resources and Services Administration				
BA	3,237	3,263	3,309	46
Outlays	2,613	2,955	3,130	175
Indian Health Service				
BA	1,960	2,000	2,174	174
Outlays	2,008	1,928	2,042	114
Centers for Disease Control and Prevention				
BA	2,125	2,155	2,230	75
Outlays	1,786	1,971	2,066	95
National Institutes of Health				
BA	11,284	11,939	12,406	467
Outlays	10,875	10,916	11,949	1,033
Substance Abuse and Mental Health Services Administration				
BA	2,195	1,854	2,098	244
Outlays	2,444	2,105	2,024	-81
Agency for Health Care Policy and Research				
BA	141	80	90	10
Outlays	139	129	97	-32
Health Care Financing Administration				
BA	245,796	261,231	295,950	34,719
Outlays	248,924	272,475	297,219	24,744
Administration for Children and Families				
BA	33,178	32,610	34,296	1,686
Outlays	31,993	32,875	33,488	613

HHS BUDGET BY OPERATING DIVISION, Continued

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Administration on Aging				
BA.....	$876	$828	$828	$0
Outlays.	951	776	819	43
Departmental Management				
BA.....	230	172	178	6
Outlays (Federal Funds)...	262	204	157	-47
Office of Inspector General				
BA.....	79	74	75	1
Outlays (Federal Funds)...	89	74	75	1
Program Support Center				
BA.....	212	220	229	9
Outlays (Federal Funds)...	208	224	225	1
Receipts				
BA.....	-45	-46	-46	0
Outlays.	-45	-46	-46	0
TOTAL, HHS				
BA.....	$302,150	$317,258	$354,695	$37,437
Outlays.	$303,107	$327,463	$354,126	$26,663
Full-time Equivalents.....	58,924	58,924	58,924	0

COMPOSITION OF THE HHS BUDGET

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Entitlement Programs (outlays):				
Medicare	$180,097	$197,427	$210,106	+$12,679
Medicaid	89,070	94,892	105,571	+10,679
Family Support Payments to States	17,133	17,366	17,955	+589
Foster Care and Adoption Assist	3,244	3,740	4,144	+404
Social Services Block Grant	2,797	3,183	2,839	-344
JOB Opportunities and Basic Skills	1,012	1,000	1,000	0
State Legalization Impact Assist. Grts	4,000	0	0	0
Family Support and Preservation	150	225	201	-24
Other/Financing Offsets	(26,203)	(21,918)	(20,537)	+1,381
Subtotal, Entitlement Programs: Outlays	$271,300	$295,915	$321,279	+$25,364
Discretionary Programs (Budget Authority):				
National Institutes of Health	$11,284	$11,939	$12,406	$467
Other Public Health Programs	10,335	10,050	10,587	537
HCFA Program Management	2,178	2,132	2,202	70
Children & Family Services Programs	4,876	4,825	5,280	455
Low Income Home Energy Assistance	1,419	1,000	1,000	0
Grants to States for Child Care	948	935	1,049	114
Administration on Aging	876	828	828	0
Refugee & Entrant Resettlement	406	405	382	-23
Departmental Management	171	151	154	3
Office for Civil Rights	22	19	22	3
Office of Inspector General	79	74	75	1
Subtotal, Discretionary Programs: Budget Authority	$32,594	$32,358	$33,985	$1,627
Outlays	31,807	31,548	32,847	1,299
TOTAL, HHS OUTLAYS	$303,107	$327,463	$354,126	+$26,663

* Based on levels of the ninth CR, including an incremental policy adjustment.
** Does not add due to rounding.

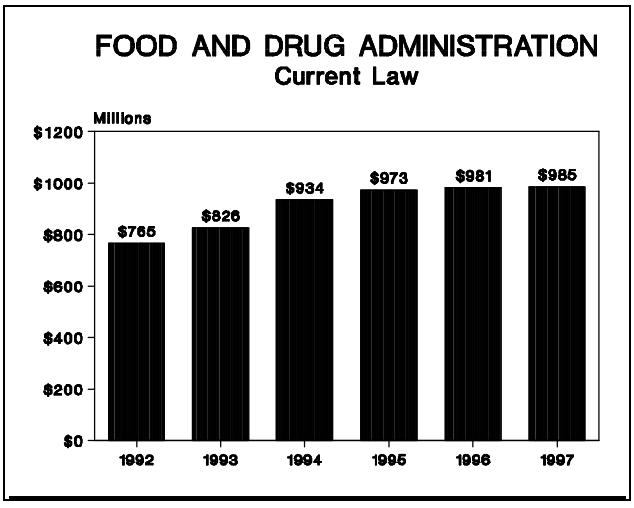
FOOD AND DRUG ADMINISTRATION

(Dollars in millions)

	1995 Actual	1996 Enacted	1997 Request	Request +/-Enacted
Current Law:				
Program Level	$973	$981	$985	+$4
Budget Authority	882	878	878	0
Outlays	860	877	881	+4
Proposed Legislation:				
Program Level		0	$39	+$39
Budget Authority		0	0	0
Outlays		0	0	0
Total, Net Proposed Law:				
Program Level	$973	$981	$1,024	+$43
Budget Authority	882	878	878	0
Outlays	860	877	881	+4
FTE	9,264	9,264	9,264	0

Summary

The FY 1997 budget request for the Food and Drug Administration (FDA) under current law is $985 million in program level spending, of which $107 million is to be derived from authorized, targeted, industry-specific user fees. In addition, FDA is proposing two new additive user fees bringing the total proposed program level spending to $1,024 million, a $43 million increase over FY 1996. Under the FY 1997 request, total budget authority will be maintained at the FY 1996 level.



Food Safety

Although the United States has the safest food supply in the world, the Centers for Disease Control and Prevention estimate that there are as many as 9,000 food-related deaths and 80 million food-related illnesses each year in this country. The annual costs for hospital stays alone related to food-borne disease are estimated to be $3.1 billion, with seafood-related illnesses costing about $144 million annually. FDA is proposing a series of Food Safety initiatives to address current concerns and to meet the safety issues the Nation is likely to face in the 21st century. A modest $4 million increase would allow FDA to expedite implementation of the new Seafood Hazard Analysis Critical Control Point (HACCP) program, expand and develop new partnerships with academia and industry to increase our food science capabilities, and use third party reviewers to improve the timeliness and efficiency of the food additive petition review process.

Prescription Drug User Fees

The Prescription Drug User Fee Act (PDUFA), first implemented in 1993, has been highly successful in enabling FDA to significantly accelerate approval of safe and effective human drugs. FDA has met or exceeded all of the Act's performance goals to date. Already, FDA has achieved one of the major 1997 performance goals in FY 1994--a full three years ahead of schedule. For the drugs submitted to FDA in FY 1994, FDA reviewed and acted upon 96 percent of them on time. In most cases, that meant action within 12 months. The backlog of overdue applications has been eliminated. To sustain momentum toward reaching the final performance goals in FY 1997, the FY 1997 budget includes $87.5 million in user fees, a 7 percent increase. This will provide for additional review staff, bringing FDA to a total PDUFA staffing increase of 700 FTE.

Mammography Quality Standards Act

FDA will continue to implement the Mammography Quality Standards Act to assure that women receive quality mammography from facilities that maintain a high standard of safety and accuracy. In FY 1997, FDA will focus its energies on ensuring that all facilities are meeting the quality standards for mammography and that identified deficiencies are corrected. By the end of FY 1996, for the first time, certified personnel will have inspected over 10,000 facilities in all. During FY 1997, FDA will fund 10,000 annual inspections and will conduct 3,000 facility recertifications. To achieve these goals, the FDA request includes $26 million for implementing the Mammography Quality Standards Act, of which $13 million is to be collected in fees from inspected facilities, as authorized by the Act.

Proposed New User Fees

In FY 1997, FDA is requesting authority to implement two new user fee activities totalling $39 million. Of these fees, $24 million is to accelerate the medical device approval process and $15 million is to improve the effectiveness and efficiency of its imported products regulatory compliance program. FDA is proposing to incorporate the concepts embodied in

the highly effective Prescription Drug User Fee Act into the medical devices field to eliminate the current backlog and to reduce the time it takes to approve medical device applications. The user fee goal is to increase the percentage of pre-market notification (510-(k)) applications completed within 90 days from 50 percent in FY 1995 to 90 percent in FY 1997, and pre-market approval applications completed within 180 days from 44 percent in FY 1995 to 75 percent in FY 1997. The new import user fee will provide FDA the resources necessary to substantially reduce the risk posed by potentially harmful foods and other products that reach the American marketplace through import channels.

FDA OVERVIEW

(Dollars in millions)

	1995 Actual	1996 Enacted	1997 Request	Request +/-Enacted
Current Law:				
Salaries & Expenses:				
Foods	$215	$222	$226	+$4
Drugs	445	446	449	+3
Medical Devices	166	170	170	0
National Center for Toxicological Research	35	38	38	0
Program Management	43	42	42	0
Subtotal, Salaries & Expenses	$904	$918	$925	+$7
GSA Rental Payments	46	46	46	0
Buildings & Facilities	18	12	8	-4
Revolving Fund	5	5	6	+1
Subtotal, Program Level	$973	$981	$985	+$4
Less User Fees:				
Prescription Drugs	$79	$85	$88	+$3
Mammography Inspection	7	13	13	0
Revolving Fund	5	5	6	+1
Subtotal, User Fees	$91	$103	$107	+$4
Total, BA	$882	$878	$878	0
Proposed Law:				
User Fees:				
Medical Devices		*$0*	*$24*	*+$24*
Import Inspection		*0*	*15*	*+15*
Subtotal, User Fees		*$0*	*$39*	*+$39*
Total, Program Level	*$973*	*$981*	*$1,024*	*+$43*
FTE	9,264	9,264	9,264	0

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Program Level	$3,042	$3,091	$3,122	+$31
Budget Authority	3,031	3,083	3,116	+33
Outlays	2,455	2,803	2,979	+176
FTE	2,010	2,010	2,010	0

* Based on levels of the ninth CR, including an incremental policy adjustment.

Summary

The FY 1997 budget request for the Health Resources and Services Administration (HRSA) is $3.1 billion. HRSA is responsible for developing primary health care services and resources, providing access to health care for the medically underserved, protecting and improving the health of all mothers and children, and maintaining a high quality of health care nationally. As managed care is becoming an increasingly important component of health care delivery at the State and local level across the United States and medically underserved populations served by HRSA programs are being directed into managed care, HRSA is addressing these changes.

HRSA has established a Center for Managed Care to coordinate activities across HRSA and has initiated new efforts to ensure that HRSA funded programs are active and knowledgeable participants in managed care systems, that managed care providers are aware of and actively attempting to meet the needs of underserved populations, and that an appropriately trained primary care workforce exists to provide services in managed care settings. HRSA has supported the creation of networks for managed care to assure that its health centers and other HRSA grantees can negotiate arrangements with State Medicaid agencies and HMOs. HRSA has offered over 100 managed care training sessions in medical management, information systems, contract negotiations, and financial risk assessment. In addition, special training programs have been offered to providers of care for special populations--HIV infected individuals, mothers and children, and the homeless--tailored to their specific needs.

Ryan White

The Ryan White AIDS CARE Act has enabled over 300,000 individuals with HIV and AIDS to receive health and supportive services, allowing many, who would have died, to live and lead productive lives. The FY 1997 request of $807 million for the Ryan White activities, a $32 million, or 4 percent increase over the FY 1996 level, continues our commitment to improve the quality and availability of care for individuals and families with HIV and AIDS. This request includes an additional $17 million for Emergency Relief for Cities (Title I) to ensure that each of the 42 metropolitan communities funded in FY 1995 and the up to ten additional cities eligible in FY 1996 will receive the same formula grant as well as provide funds to any newly eligible communities in FY 1997. Included in the request is $285 million, or a 4 percent increase, for formula grants to States to improve services in areas with critical gaps for underserved and hard to reach populations, as well as to augment States' flexibility in selecting pharmaceuticals. A total of $64 million, or a 3 percent increase, is requested in discretionary grants to allow an additional five to ten thousand individuals who are infected with, or at-risk of, HIV infection to receive primary care services. For Title IV pediatric projects, a total of $34 million is requested, a 6 percent increase, which will provide enhanced services for preventing maternal HIV transmission.

On March 5, 1996, the President proposed a $52 million budget amendment for the AIDS Drug Assistance Program (ADAP). The ADAP program provides AIDS drugs that prolong and enhance the quality of life for the over 55,000 individuals currently enrolled. This increase is needed to assist States in making available to patients the long-anticipated new class of AIDS drugs, protease inhibitors, as soon as they are approved by the FDA. Protease inhibitors, used in combination with already approved AIDS drugs, are expected to improve the length and quality of life for individuals suffering from AIDS.

Consolidated Health Centers

The FY 1997 request for the Consolidated Health Centers cluster provides $757 million for grants to local health centers which serve vulnerable underserved populations, including migrant workers, homeless individuals, and residents of public housing. This funding level maintains our commitment to ensure that the most vulnerable of our populations receive quality health care. These community-based centers provide accessible, quality, primary health care to more than 8.1 million medically underserved individuals--44 percent of whom are children--through over 720 grantees at 2,204 sites nationwide. Today, over 150 health centers are involved in managed care contracting throughout the Nation, primarily serving Medicaid managed care patients.

Health Professions

The FY 1997 budget request for health professions programs is $366 million. HRSA is continuing to propose consolidation of numerous separate health professions training programs into five clusters over a period of three years. The cluster strategy allows greater flexibility in effectively responding to emerging health workforce challenges. The clusters will enhance our ability to assist students financially, encourage expansion of

multi-disciplinary, outcome-oriented primary care training, as well as bring simplicity to the administrative processes of application submission and grant issuance.

- The Health Professions Workforce cluster ($117 million) will merge six student assistance programs into one program, providing student assistance through obligated financial assistance, non-service subsidized loans, and non-service market rate loans, as well as focus on national workforce research and data efforts. This cluster will include the entire National Health Service Corps.

- The Enhanced Area Health Education Training cluster ($35 million) incorporates eight categorical programs into one program which will require the formation of consortia to link educational systems with States, communities and employers to expand the operation of interdisciplinary, outcome-oriented training. This critical effort ties medical education to the service needs of the underserved. It provides benefits to those being trained so that they receive solid grounding in practical health care. It also provides benefits to States and communities by providing knowledgeable individuals prepared to deal with the health issues they face.

- The Minority and Disadvantaged Health cluster ($64 million) consolidates seven programs into one program which will support targeted, outcome-oriented activities that increase the number of minority and disadvantaged health professionals. This program will help advance the development of human potential and strengthen the capacity of Historically Black Colleges and Universities and Hispanic Serving Institutions. This cluster will eliminate restrictive eligibility and project requirements while increasing flexibility in responding to minority health needs.

- The Primary Care Medicine and Public Health Training cluster ($80 million) consolidates six programs. This program will fund comprehensive, flexible, and effective activities that will increase the number and enhance the quality of primary medical care providers and public health workers in order to meet National, State, and local health care needs.

- The Nursing Education Practice Initiatives cluster ($70 million) combines six programs into three activities focusing on basic nurse training, advanced practice nurse training, and workforce diversity. It provides solid reinforcements to our continued efforts to help provide well-trained individuals in this key component of the health care workforce.

Services to Mothers and Children

In keeping with the Department's strong commitment to investing in programs which support Strong Foundations and Safe Passages for our Nation's children, the HRSA budget supports funding for several programs with the sole mission of improving the health of women of childbearing age and their children. These programs include the Maternal and Child Health Block Grant, a total program level of $681 million; Healthy Start, a total program level of $75 million; and the Title X Family Planning program, a total program level of $198 million, an increase of $5 million, or 3 percent, over FY 1996. The family planning program provides

services to approximately four million persons, primarily women and adolescents, in over 4,000 clinics nationwide. The funds will increase outreach to underserved individuals, place an emphasis on comprehensive reproductive health services, and focus on adolescent pregnancy and sexually transmitted disease prevention.

Other HRSA

For the remaining HRSA programs, total spending of $238 million is proposed. This level will ensure sufficient funds are available to adequately fund rural health initiatives such as telemedicine, critical to assisting rural physicians in their daily practice, and internal HRSA initiatives such as technology improvements and workforce development to allow HRSA to continue to streamline its workforce and organization while maintaining a high level of service to the vulnerable populations it serves. In addition, this level will allow HRSA to keep its organ transplantation and Bone Marrow Donor programs viable.

HRSA OVERVIEW

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Ryan White	$633	$775	$807	+$32
Other AIDS Services	23	12	23	+11
Community Health Centers	757	756	757	+1
Health Professions Clusters:				
Workforce Development	124	115	117	+2
Enhanced Areas Health Education	48	42	35	-7
Minority/Disadvantaged	91	81	64	-17
Primary Care Medicine & Public Health	79	74	80	+6
Nurse Education	59	56	70	+14
Subtotal, Health Professions	$401	$368	$366	-$2
Maternal and Child Health Block Grant	$684	$681	$681	$0
Healthy Start	104	75	75	0
Family Planning	193	193	198	+5
Special Populations Cluster	17	12	8	-4
Rural Health Research	9	8	8	0
Rural Outreach	26	43	30	-13
Malpractice Databank	11	8	6	-2
Program Management	124	114	116	+2
Other Services	60	46	47	+1
Subtotal, Disc. Program Level	$3,042	$3,091	$3,122	+$31
Offsets	-11	-8	-6	+2
Total, BA	$3,031	$3,083	$3,116	+$33
FTE	2,010	2,010	2,010	0

* Based on levels of the ninth CR, including an incremental policy adjustment.

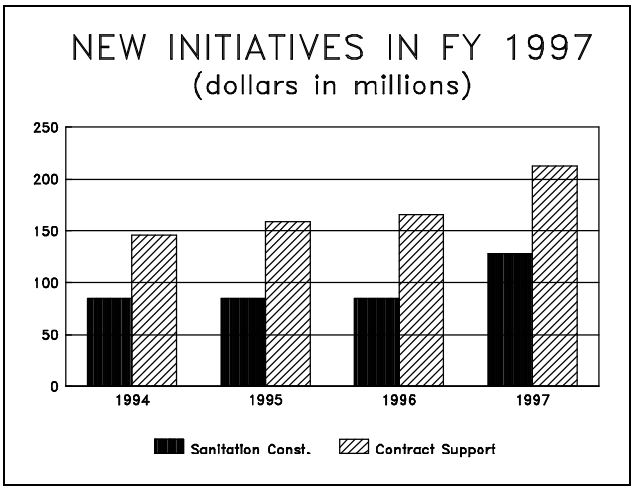
INDIAN HEALTH SERVICE

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Program Level	$2,156	$2,214	$2,400	+$186
Budget Authority	1,960	2,000	2,174	+174
Outlays	2,008	1,928	2,041	+113
FTE	14,856	14,856	14,856	0

* Based on levels of the ninth CR, including an incremental policy adjustment.

Summary



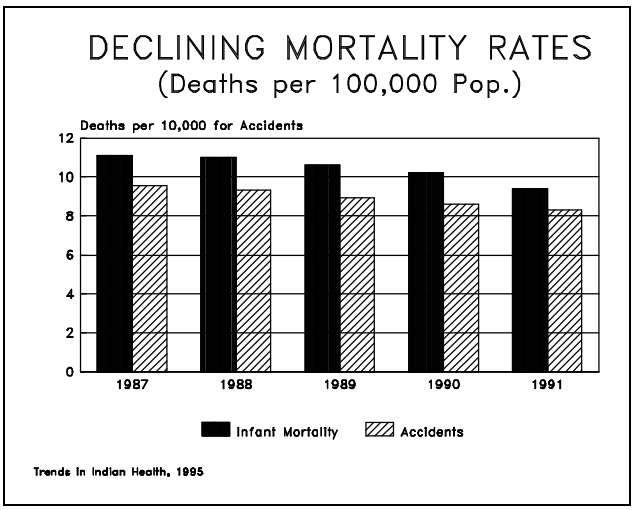
The FY 1997 budget request for the Indian Health Service (IHS) is $2.4 billion. Additional funds will be used primarily for sanitation construction, to make it easier for tribes to take over the operation of their local health programs, to provide additional staff in six new/expanded health facilities, and to increase services for populations with special needs (e.g., women, children, urban Indians, the elderly). The request assumes collection of $222 million in insurance payments (e.g., Medicaid, Medicare, employer provided) for Indian patients, consistent with FY 1996 levels (total FY 1997 reimbursements of $226 million include $4.5 million from rental of quarters).

Agency Description

IHS provides medical care to about 1.4 million American Indians and Alaska Natives (AI/AN) who are members of Federally recognized tribes. Care is provided directly through a network of 49 hospitals and 484 health centers and stations located primarily in Oklahoma, the Northern Plains, California, Alaska, and the Southwest. Local tribes operate 11 of the hospitals and 372 of the centers and stations under contract with IHS. Medical care is also purchased ($369 million in FY 1997) for Indian patients from local hospitals and medical providers. While care is primarily provided in areas which are on or near reservations, funds are also provided to urban health grantees ($27 million in FY 1997) in 41 cities with large

AI/AN populations. In addition to providing medical care, IHS provides preventive and environmental health services, mental health care, and alcohol/substance abuse prevention and treatment. IHS also provides funds to increase the supply of AI/AN health care providers and as incentives for health care professionals to practice in Indian country.

The health statistics for Indian people have improved dramatically, both in absolute terms and in comparison with all Americans, since IHS began keeping records in the early 1970s. Two areas which have seen significant improvement in recent years are infant mortality and deaths from accidents. Infant mortality has declined by 15.3 percent while the death rate for accidents has declined by 12.8 percent.



IHS Restructuring

The final report of the Indian Health Design Team (IHDT) was published in November of 1995, the product of more than a year's worth of development, including extensive feedback from IHS' customers (i.e., tribes, tribal organizations, and individuals throughout Indian country) and employees. The IHDT recommends shifting control to the local level where IHS staff or tribal self-determination contractors provide health care. Headquarters and regional operations will be consolidated to provide additional dollars and staff for health care operations. Implementation has begun with the restructuring of IHS' headquarters, reducing ten existing offices to three (Office of the Director, Office of Health Support, Office of Administrative Support). The second phase of implementation will consolidate operations at IHS' twelve regional or area offices, each one of which now oversees all IHS operations in a geographic area. Administrative support functions (e.g., finance, procurement, personnel) will be consolidated in Regional Support Centers. Health Professions support (e.g., maternal and child health, injury prevention, consultations with local health care providers) will also be consolidated into a smaller number of specialty sites. The IHDT recommendations will also reduce headquarters and area office budgets and free up FTE for local health care provision.

Changes From FY 1996

The FY 1997 budget requests an increase in budget authority of $174 million (+8.7 percent) primarily for Clinical Services (+$80 million), Self-Determination Contracting (+$46 million), and Sanitation Construction (+$43 million). The request also assumes an increase of $12 million in insurance collections (+5.3 percent). Insurance collections are used to make improvements to hospitals and health clinics identified by accreditors from the Health Care Financing Administration and the Joint Commission on Accreditation of Health Care Organizations.

The additional $174 million will fund a number of new initiatives in FY 1997:

- Self-Determination Funds ($212 million; +$46 million): The request provides an increase of 28 percent to cover contract support costs, which are the management expenses tribes incur when they take over the operation of local health programs from IHS. The Indian Self-Determination Act gives tribes the right to take over these operations but their ability to do this is hindered unless sufficient funding is available for contract support costs. Tribally operated programs have increased steadily since the Act's passage and accounted for about 37 percent of IHS' budget in FY 1995.

- Sanitation Construction ($128 million; +$43 million): IHS has been providing water and waste disposal services to Indian homes since 1960, helping to increase the number of homes with such service from about 20 percent to over nearly 90 percent. Of the $128 million, $86 million will be used to provide services to 17,400 existing homes (up from 8,800 in FY 1996), and $42 million will be used to provide services for new homes as they are built (the same as in FY 1996).

- Health Initiative for Special Populations (+$16 million): IHS will begin four special initiatives focused primarily on the needs of women, children, elders, and urban Indians. Funds will be used for outreach services aimed at preventing domestic violence (women and children), other preventive services for women (diabetes, cancer, alcohol and substance abuse), to provide training and access to off-reservation services to better serve the growing elderly population, to provide additional services to urban Indians, and to expand community efforts to reduce injuries (e.g., DWI, seat belts/child restraints, sports injuries, violence, pedestrian/motor vehicle collisions).

- Operation of New Facilities (+$27 million): The request includes funds necessary to provide an additional 382 staff for six facilities opening in FY 1996 and FY 1997. These facilities are Harlem (MT), White Earth (MN), Kotzebue (AK), Shiprock (NM), Anchorage (AK), and Hayes (MT). IHS is not proposing to increase its total staff level between FY 1995 and FY 1997. To the extent these new staff are Federal employees, they will be offset by staff reductions primarily in headquarters and area offices.

- Other Initiatives (+$7 million): The request also includes $3.5 million to purchase medical services for five newly recognized tribes (Mohegan Indian Tribe of Connecticut; Jena Band of Choctaw of Louisiana; and three tribes from Michigan: Little Traverse Band of Odawa, Little River Band of Ottawa, Pokagon Band of Potawatomi), $2 million for health professions scholarships, and $1.5 million for system upgrades and improved electronic communication.

IHS is also requesting $44 million for pay costs and inflation, and for the costs associated with turning area and headquarters operations over to contracting tribes (e.g., change of duty station, severance pay). Dollars requested for new health facility construction will be reduced (-$9 million) with the full funding of all ongoing facilities construction occurring in FY 1996 (Hayes, MT and White Earth, MN). IHS will complete design of three facilities in FY 1997--Pinon, Ft. Defiance, and Hopi (Second Mesa)--all located in Arizona.

IHS OVERVIEW

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Services:				
Clinical Services	$1,370	$1,418	$1,498	+$80
Preventive Health....	77	78	82	+4
Direct Operations....	50	49	51	+2
Self-Determination Contracting	159	166	212	+46
Other	51	50	56	+6
Subtotal, Services	$1,707	$1,761	$1,899	+$138
Facilities:				
Sanitation Construction.....	$85	$85	$128	+$43
Facility Construction.....	28	12	3	-9
Fac/Envir Health Support ..	88	90	92	+2
Other	52	52	52	0
Subtotal, Facilities	$253	$239	$275	+$36
Total, BA	$1,960	$2,000	$2,174	+$174
Reimbursements.....	196	214	226	+12
Total, Program Level ...	$2,156	$2,214	$2,400	+$186
FTE	14,856	14,856	14,856	0

* Based on levels of the ninth CR, including an incremental policy adjustment.

CENTERS FOR DISEASE CONTROL AND PREVENTION

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Program Level	$2,223	$2,256	$2,343	+$87
Budget Authority	2,125	2,155	2,230	+75
Outlays	1,786	1,971	2,066	+95
FTE	6,645	6,592	6,592	0

* Based on FY 1996 appropriation, including an incremental policy adjustment.

Comparable Table--includes Bureau of Mines Safety and Health Research comparable figures for FY 1995 and FY 1996.

Summary

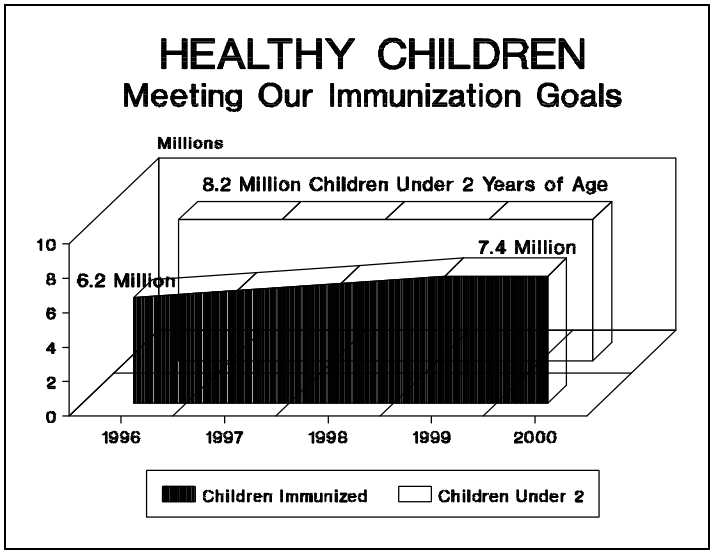
The FY 1997 President's Budget request for the Centers for Disease Control and Prevention (CDC) provides a $2.3 billion level of spending.

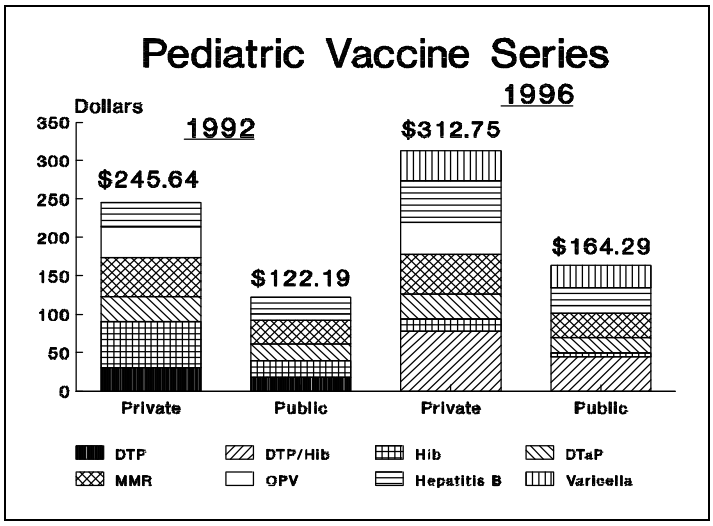
CDC is the leading public health agency responsible for disease prevention and health promotion efforts. Consistent with the strategies articulated in the Healthy People 2000 report, emphasis is placed on expanding proven prevention services which target improving the health status of all Americans. Special attention is placed on healthy lifestyles at an early age and on preventing costly health problems, particularly those affecting the economically disadvantaged. As this nation moves closer to the millennium, CDC is focusing on developing measures of prevention effectiveness and health outcomes.

Childhood Immunization

It is the Administration's goal that, no later than the year 2000, at least 90 percent of the nation's two-year-olds will be fully immunized. Over the past three years, investments in childhood vaccines and State vaccine delivery infrastructures have moved the Nation further toward accomplishing this goal. For 1995, the National Immunization Survey (NIS) indicates that 75 percent of our two-year-olds are now fully immunized compared to just 55 percent in 1992. In FY 1997, the Administration will spend a total of $1.0 billion on childhood immunization--$488 million on CDC discretionary programs and $524 million on the Vaccines for Children (VFC) entitlement program.

As part of its broad Childhood Immunization Initiative, the CDC has been working toward global polio eradication--and this goal is within reach--achievable by the year 2000. The FY 1997 request includes an increase of $20 million, or a total of $47 million, for global polio eradication. Data now indicate that polio cases are down by 80 percent globally since 1988. According to 1994 data, 145 countries in the world are already polio-free. Yet, the World Health Organization (WHO) estimates that over 100,000 children are needlessly crippled by polio paralysis each year.





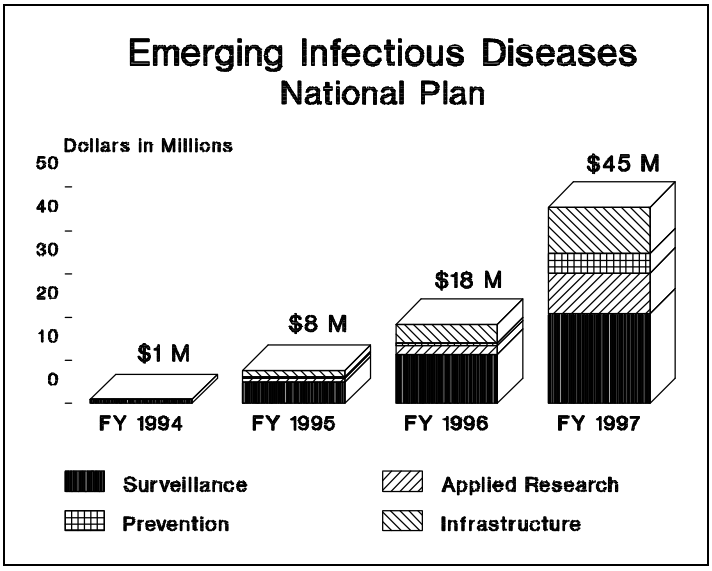
Over the past year, tremendous strides have been made in implementing the new VFC entitlement program. Over 39,000 providers in the U.S. have been recruited to provide VFC vaccines to Medicaid, uninsured, underinsured, American Indian, and Alaska Native children at their first medical point of contact. Enrolling providers in VFC reduces the missed opportunities for immunization formerly caused by provider referrals to public health clinics which required parents to make a second trip away from a child's medical home for vaccinations. In FY 1996, the VFC program will become fully operational and Medicaid payments for vaccines will be completely phased out. For the first time in FY 1996, CDC also will be able to help States target resources to pockets of need because of the new National Immunization Survey.

HIV/AIDS

A total of $617 million, an increase of $34 million (6 percent) over FY 1996, is requested for CDC HIV/AIDS prevention programs. The request includes $20 million for applied HIV/AIDS research which will enable CDC and its prevention partners to identify effective interventions for specific populations, for instance--women; injecting drug and other substance abusers; and high-risk youth, both in and out of school. In addition, $12 million will be used to build on the community planning model established by the HIV/AIDS program last year. This model gives grantees broad discretion in setting program priorities and determining how funds will be spent--resulting in customized programs necessary to meet

the needs of diverse communities across this nation. This flexibility permits communities to target resources to where they are most needed and will have the most impact--for instance meeting the needs of adolescents. Also requested is an increase of $2 million to meet the growing demand for tuberculosis testing of HIV-infected individuals. Of the total request, $298 million will be awarded through an HIV/AIDS Performance Partnership Grant and $319 million will remain with CDC for national outreach and education, technical assistance, and research.

New and Emerging Infectious Diseases



In recent years, infectious disease outbreaks have taught us that we are susceptible to infectious diseases--HIV, plague, and influenza are good examples of that risk. Potential threats to U.S. health are steadily escalating because of increasing global interdependence, modern transportation, trade, and changing social and cultural patterns. CDC is seeking a total of $88 million for infectious disease activities. Of this amount, $45 million is included to implement the CDC national prevention strategy for addressing emerging infectious disease threats--an increase of $26 million over FY 1996. Since FY 1993, CDC's total budget for preventing and controlling infectious diseases has more than doubled. The FY 1997 request will provide financial and technical support to 30 State health departments for surveillance, epidemiologic and laboratory investigations, and educational programs on infectious diseases, including rapid identification and investigation of outbreaks and drug resistant diseases. Three additional population-based Emerging Infections Programs would be established, for a total of eight nationwide.

This investment has the potential to reduce the burden of illness due to infections and reduce health care costs substantially. For example, *Salmonella* infections now kill at least 1,000 Americans a year and add $1 billion in medical costs to the country's health care burden; *Campylobacter* infections add another $1 billion to our nation's health care bill; and influenza produces direct medical costs approaching $5 billion and lost productivity costs of almost $12 million each year.

HHS Survey Integration -- National Health and Nutrition Examination Survey (NHANES)

HHS has closely reviewed its health data surveys and produced a long-range plan for health survey integration. This plan calls for linkages--field work, study samples, data collection questionnaires, etc.--and will result in more comprehensive data collection and analysis--as well as saving resources from economies of scale. In addition, surveys that were once periodic (done once a decade) are being converted to continuous surveys with the same periodicity--to be more responsive to the fast pace of the nation's health care enterprise. For the National Center for Health Statistics, the request totals $90 million for health statistics in FY 1997.

The FY 1997 request includes an increase of $10 million, or a total of $14 million, for the National Health and Nutrition Examination Survey (NHANES). As part of the HHS survey integration plan, NHANES will be linked to the Medical Expenditure Panel Survey (MEPS) and the National Health Interview Survey (NHIS). The analytic linkage of these three surveys is crucial for providing ongoing monitoring of our nation's health status, insurance, expenditures, and health risk and behaviors.

NHANES is a consolidation of data efforts of multiple agencies and departments, not just CDC or HHS. Food fortification policy at FDA relies on NHANES measures, as does monitoring of toxicants for the EPA. NHANES provides unique information through direct physical examinations, biochemical measures, and nutritional analysis from a large, representative sample of persons. By direct standardized measurements, NHANES is able to objectively measure health conditions and risks, even if they are not known to the survey respondent.

NHANES also is the only national source of objectively measured health status data, and is essential to interpreting information from other integrated survey components. NHANES obtains direct measures of health necessary to measure the outcomes--not just the costs of--investments in health. These data also allow us to relate health care needs to health care use and expenditures. NHANES is an important part of national surveillance capability for infectious diseases, behavioral and environmental risk factors to health, undiagnosed preventable illnesses, food safety, nutritional status, and other critical issues. No other effort in the public or private sector provides the type of information available through NHANES. Examples of NHANES data uses include monitoring of: lead exposure, toxic exposure and environmental effects, genetics, food safety (for instance, olestra), folate (food fortification impact), hypertension and cholesterol (program success), and HIV and Hepatitis C Seroprevalence (necessary to protect the national blood supply).

National Institute for Occupational Safety and Health (NIOSH)

CDC is requesting a total of $136 million in FY 1997. A major component of this request is an investment of $36 million to fully fund the NIOSH new advanced research facility. This state-of-the-art laboratory will increase the nation's occupational safety and health research capacity by more than one-third. When fully staffed, more than 300 researchers will have the opportunity to make advances in biochemistry, immunotoxicology, and molecular and

cellular biology that will be translated into information that directly assists work site health and safety programs. The facility will open in the Spring of 1996.

NIOSH programs establish and disseminate scientific and public health information necessary to ensure safe and healthful working conditions for 127 million American working men and women. Americans are working more hours than ever before, in environments that may profoundly affect their health. Even with the passage of the Occupational Health and Safety Act in 1970, and the mine safety laws that were enacted in 1969 and 1977 to protect miners, workplace hazards continue to inflict a tremendous toll in both human and economic costs. Even now, work-related injuries and illnesses still cost an estimated 63 thousand lives each year. Work injuries alone cost our economy over $100 billion a year, and occupational illnesses cost additional billions of dollars.

Research plans for the coming year will focus on occupational lung disease, musculoskeletal injuries, cancers, traumatic injuries, reproductive disorders, neurotoxic disorders, cardiovascular disease, noise-induced hearing loss, dermatologic conditions, and protective equipment. These efforts will help to address solutions to occupational disease and workplace safety concerns in those fields where the dangers are the greatest--mining, construction, transportation/communications/public utilities and agriculture/forestry/fishing.

Mine Health and Safety Research--Bureau of Mines Transfer

In FY 1997, CDC will take over the management of the health and safety research functions formerly performed by the Bureau of Mines. While the Mine Health and Safety Research program was initially transferred to the Department of Energy in FY 1996, the program will become part of the National Institute for Occupational Safety and Health (NIOSH) in FY 1997. A total of $32 million and 413 FTE is requested for continuing this program in FY 1997.

Infectious Disease Laboratories: Repair and Improvement

The FY 1997 request of $8 million for buildings and facilities includes an increase of $4 million for design and construction of 15,000 square feet of BLS-3 (Biosafety Level 3) containment laboratory space necessary to allow CDC to renovate its current laboratories which are 35 years old and deteriorating. The current building and facilities budget is not adequate to both build a new building and address CDC's backlog of building repair and improvement projects, so CDC has found offsets within programs that will directly benefit from the new laboratories. Conditions of existing laboratory space, including antiquated airhandling systems, place several hundred scientific employees at risk from highly infectious and dangerous organisms. This lab project is a top priority for the agency.

Rape Prevention/Education and Domestic Violence Demonstrations

The FY 1997 request includes $32 million from the Violent Crime Reduction Trust Fund to continue three programs authorized by the Violent Crime Control and Enforcement Act of 1994. CDC will distribute $29 million to States as part of the Prevention Block Grant for rape prevention and education, and award $3 million for domestic violence demonstration projects. These programs were first funded in FY 1996.

Chronic Diseases and Disabilities

The FY 1997 request includes $268 million to address the significant premature death and avoidable illness and disability that are caused by personal behaviors and exposure to toxic substances and natural disasters. Chronic diseases, including those present at birth, represent over 70 percent of the causes of death in the United States. Prevention of disease and its progression is based on reducing or eliminating behavioral risk factors--such as tobacco use, physical inactivity, and poor nutrition; increasing the prevalence of health promotion practices; detecting disease early to avoid complications; assessing human risks from environmental exposures; and reducing or eliminating exposures to environmental hazards. The CDC addresses a wide range of chronic and environmental diseases, including cardiovascular disease--the leading cause of death in the United States; diabetes; cancers; birth defects; reproductive disorders; and chronic fatigue syndrome.

Sexually Transmitted Diseases and Tuberculosis

The request includes $223 million to continue CDC programs to prevent and control infectious sexually transmitted diseases (STDs) and tuberculosis (TB). It is important that the Nation remain vigilant in maintaining adequate resources to hold STDs and TB in check. As recent as 1989, the U.S. had a resurgence of TB--a disease that had steadily declined since the 1940s. As a result, the CDC budget for TB has more than doubled since FY 1992--from $67 million to $145 million--and Medicaid coverage now provides approximately $130 million for State TB services in non-traditional settings (for instance in crack houses, rather than in health clinics). Data from 1994 indicate that there has been a 9 percent decline in TB cases since 1992 when the peak number of cases was reported (26,673).

Maintaining resources necessary to prevent and control STDs is a high priority. More than 750,000 cases of pelvic inflammatory disease (PID) are diagnosed and treated each year, resulting in more than 165,000 hospitalizations for women aged 15-44. Annually, PID, secondary to either gonococcal or chlamydia infection, accounts for more than 125,000 cases of tubal infertility and nearly 50,000 cases of potentially fatal ectopic pregnancy. Delay in treatment and repeated episodes of symptomatic and asymptomatic PID result in higher rates of infertility, and result in complications for children born to untreated mothers.

To further complicate matters, these diseases are now presenting new challenges to the medical establishment as more and more multi-drug resistant (MDR) strains are diagnosed.

Although once easily and cost-effectively treated with antibiotics, medical care for MDR-TB and STDs is much more costly and more often fatal than for non-MDR strains. Prevention remains our best defense.

Performance Partnership Grants

Similar to last year, the FY 1997 budget proposes to consolidate 32 CDC categorical grant programs into four Performance Partnership Grants--an HIV Grant, an STD/TB Grant, a Chronic Disease and Disability Prevention Grant, and an Immunization Grant. As proposed, these consolidations are designed to increase State flexibility, streamline Federal management, improve program performance, and ensure accountability.

With the creation of these new, simplified grants, CDC will be able to extend Federal resources to States with fewer strings attached, with less grant submissions, reviews, and negotiations, and with broader discretion at the State level to pursue their own priorities. States will be asked to submit a single annual grant application for each grant program and their performance on specific goals they choose will be monitored to see that their performance improves public health.

CDC will retain responsibility for research, demonstration, training, and technical assistance programs as well as targeted national programs including: purchasing childhood vaccines, addressing new emerging infectious diseases and environmental health issues, and eliminating child lead poisoning. CDC also will retain the existing Prevention Block Grant.

CDC OVERVIEW

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Immunizations:				
Partnership Grant	$177	$177	$177	$0
Vaccine Purchase	152	141	141	0
Other Immunization	135	150	170	+20
Subtotal	$464	$468	$488	+$20
HIV/AIDS:				
Partnership Grant	$286	$285	$298	+$13
Other HIV/AIDS	304	298	319	+21
Subtotal	$590	$583	$617	+$34
Infectious Diseases	54	62	88	+26
Health Statistics	81	80	90	+10
Occupational Safety and Health	132	137	136	-1
Mine Health & Safety Research	42	32	32	0
Building & Facilities	3	4	8	+4
Preventive Health Svcs Block Grant	158	145	145	0
Rape Prevention/Education	0	29	29	0
Domestic Violence Demos	0	3	3	0
Injury/Violence Control	44	43	43	0
Chronic Diseases & Disabilities:				
Partnership Grant	$118	$118	$117	-$1
Chronic & Environmental Diseases	103	107	106	-1
Breast/Cervical Cancer	20	45	45	0
Subtotal	$241	$270	$268	-$2
Sexually Transmitted Diseases/TB:				
Partnership Grant	$186	$183	$182	-$1
Sexually Transmitted Diseases	22	25	25	0
TB Elimination	17	16	16	0
Subtotal	$225	$224	$223	-$1
Epidemic Services	73	70	69	-1
Prevention Centers	8	8	7	-1
Lead Poisoning	36	36	36	0
Toxic Substances/Disease Registry	69	59	58	-1
Director's Office	3	3	3	0
Subtotal, Program Level	$2,223	$2,256	$2,343	+$87
Less: PHS Intra-Agency Transfers				
Receipts	-98	-101	-113	-12
Total, BA	$2,125	$2,155	$2,230	+$75
FTE	6,645	6,592	6,592	0

* Based on levels of the ninth CR, including an incremental policy adjustment.
Comparable Table--includes Bureau of Mines Safety and Health Research comparable figures for FY 1995 and FY 1996.

NATIONAL INSTITUTES OF HEALTH

(Dollars in millions)

	1995 Actual	1996 Policy	1997 Request	Request +/- Policy
Program Level	$11,295	$11,950	$12,435	+$485
Budget Authority	11,284	11,939	12,406	+467
Outlays	10,875	10,916	11,949	+1,033
FTE	15,474	15,474	15,474	0

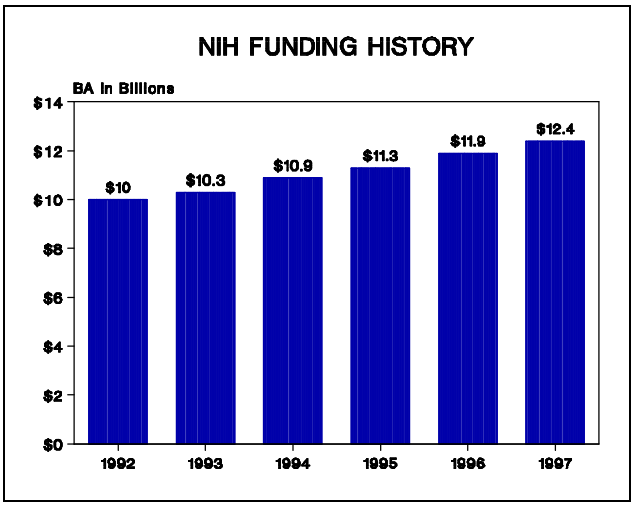
Summary

The FY 1997 request for the National Institutes of Health (NIH) totals $12.4 billion, an increase of $467 million, or 4 percent, over the FY 1996 level. This includes an additional $274 million related to the construction of the Clinical Research Center and an additional $193 million for research activities. NIH has constructed its budget request to minimize the impact on research project grants of this one-time extraordinary facilities cost.

Our Nation's historic commitment to biomedical research has spawned a steady march of progress--from the creation of new drugs targeted to specific diseases to the mapping of the human genome. NIH is the preeminent biomedical and behavioral research organization in the United States and provides world leadership in these fields through the conduct, support, and promotion of outstanding research both in its own intramural laboratories and in partnership with over 2,000 of our country's colleges, universities, and other scientific institutions. The Institutes and Centers funded by NIH's 24 appropriations are committed to supporting initiatives having the greatest potential for improving health, reducing the risk of disease, and ultimately, improving the quality of human life.

Investments in research are the engines of long-term economic progress. This is why, in a time of limited growth across the Federal Government, this Administration continues to fight for steady increases in research, as evidenced with this FY 1997 budget request for NIH. In the past three years, these efforts have paid off, time and time again. They have helped lead to the discovery of three genes linked to hereditary breast cancer; to the first drug treatment for severe sickle cell anemia; to the first treatment for the most common form of stroke; to five new licensed anti-viral drugs for people living with HIV/AIDS; and to three recently approved protease inhibitors, a whole new class of drugs to combat AIDS. Yet, these advances were also the culmination of many smaller, less dramatic discoveries over many years, which demonstrate the need to take the long view of basic research. A panel of experts sent a tough wake-up call last December when it concluded that the promise of gene therapy, while awe inspiring, is still miles away from being realized. It reminded us that we must

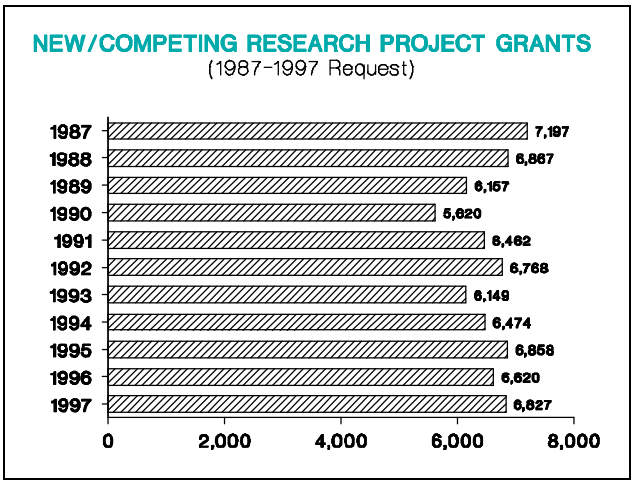
invest more in the foundation of our scientific universe, in the incremental gifts of basic science that help us unleash blockbuster discoveries over time. Stable and secure funding is needed to nourish the seeds of research, to create an atmosphere in which young investigators are pulled into science, inspired to stay there, and ultimately train the next generation of scientists.

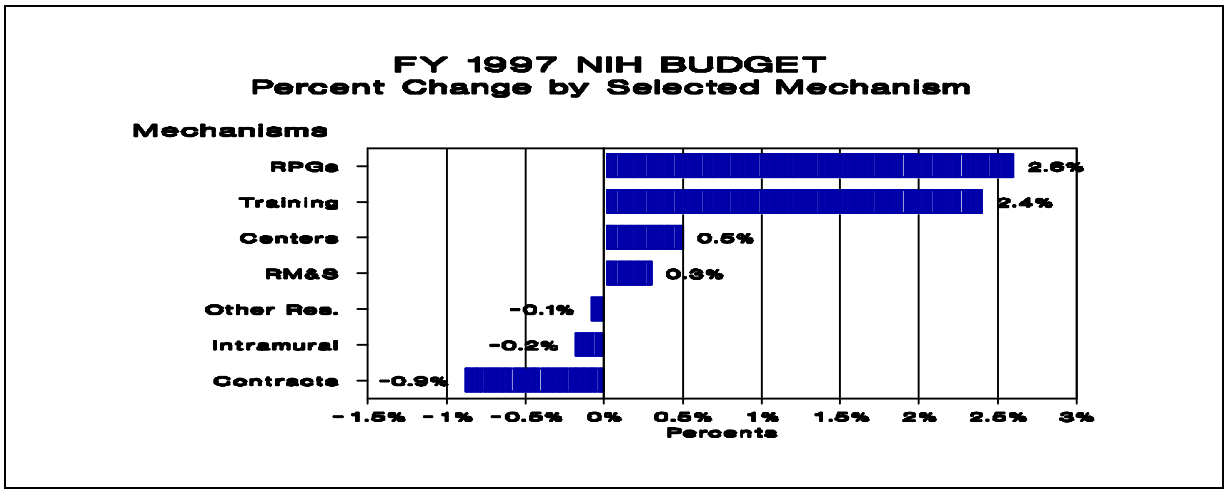


For FY 1997, NIH has identified five biomedical research areas for emphasis in which it sees an opportunity to explore a set of emerging technologies, approaches, and treatments that will help expand the frontiers of biomedical knowledge and that offer great promise for curing disease and furthering the Nation's health. NIH plans to spend an additional $99 million in FY 1997 to emphasize research on the biology of brain disorders; on new approaches to pathogenesis, the study of disease origins and development; on new preventive strategies against disease; on genetics of medicine; and on advanced instrumentation and computers in medicine and research.

Research Project Grants

The highest priority of NIH is the support of basic biomedical research through investigator-initiated research project grants (RPGs). These grants support new and promising ideas cutting across all areas of biomedical research. In FY 1997, the NIH budget provides $6.6 billion to support a record total of 25,400 RPGs, including 6,827 new and competing RPGs. This represents an increase of 207 new and competing RPGs, and an increase of 733 in the number of total RPGs compared to FY 1996. In recognition of its importance to the NIH mission and the current state of knowledge for future breakthroughs in many disease areas, NIH is devoting 86 percent (+$166 million) of its non-facilities increases in FY 1997 to the RPG mechanism. Funds for small business research and technology transfer grants are also slated to rise by $43 million in FY 1997, in accordance with statutory earmarks. In addition, NIH is continuing its pilot studies to fine-tune and streamline the peer-review system to ensure that every dollar counts and that research funds are spent wisely and effectively.





Clinical Center Revitalization

A major feature of the FY 1997 President's budget for NIH is the commitment to revitalize both the operations and the facilities of the Warren G. Magnuson Clinical Center. The Center is the core clinical research facility at NIH and is the largest of its kind in the world. It provides protocol-specific patient care in support of the intramural research programs sponsored by most NIH Institutes, and serves as a resource for training clinical investigators. Each year, an average of 20,000 children and adults from across the country, and in some instances, the world, are referred to the Clinical Center for experimental treatment and study. These patients account for approximately 65,000 inpatient days and 70,000 outpatient visits a year. Nearly 1,000 clinical research protocols are ongoing at the Clinical Center at any one time. This represents approximately 25 percent of all Federally funded outpatient visits associated with clinical research and nearly half of all the Federally funded clinical research beds in the Nation. Funding for the Clinical Center is derived from assessments on the participating Institutes and Centers.

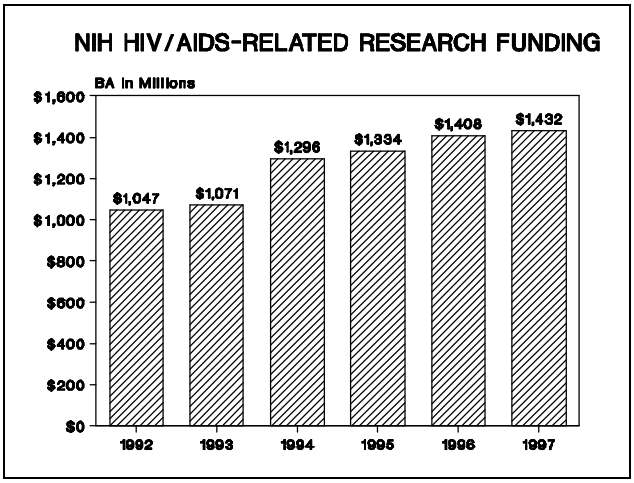
An "Options Team," created by the Secretary last summer, recently completed a thorough review of Clinical Center operations. The Options Team has identified numerous processes and structures that will be reengineered to improve the effectiveness and efficiency of the Clinical Center. The Team's report recommended fundamental alterations in the way the Clinical Center is governed, funded, and managed. As a result, a new Board of Governors is being created to oversee the operations and budgeting of the Clinical Center and to assist it in developing strategic, long-term planning with measurable objectives. NIH has committed to ensure that funding for the Clinical Center is made more stable through its Management Fund assessments and through a budget proposal to make such funds available for two years, instead of the usual one. Authority is also being sought to allow the Clinical Center to collect and keep third-party reimbursements for some patient services. Furthermore, as a result of its intensive self-review, the Clinical Center has initiated steps to reduce regulations, enhance autonomy, and improve personnel and procurement practices.

In addition, the FY 1997 President's budget for NIH requests a total of $310 million for the construction of a new, state-of-the-art Clinical Research Center on the NIH campus in Bethesda, Maryland, to replace the 500-bed hospital component and build some additional

associated laboratories. The current facility was built in the early 1950s and is now physically deteriorated and is becoming functionally obsolete. This budget request is the product of over seven years of study of NIH's facilities, including critical independent assessments by the U.S. Army Corps of Engineers in 1991, and the NIH Director's External Advisory Committee on the NIH Intramural Research Program in 1994 which recommended the Clinical Center's hospital component be downsized from the current 500-bed capacity to a 250-bed facility. This new facility will be more efficient to run, more affordable to maintain, more flexible to staff, and more rapidly adaptable to the clinical challenges of the future. Together, these operational and facilities improvements will ensure that the Clinical Center flourishes well into the next century as the national core of clinical research.

Office of AIDS Research

The FY 1997 President's budget again includes all of NIH's AIDS-related funds--$1.4 billion--in a single account for the Office of AIDS Research (OAR), as these funds were appropriated in FY 1995. The Director of OAR will transfer AIDS funds to the Institutes in accordance with the comprehensive plan for AIDS research developed by the OAR along with the Institutes. The Administration strongly supports a consolidated AIDS appropriation as a vital part of ensuring a coordinated and flexible response to the AIDS epidemic.



The AIDS research effort is unlike any other program at the NIH in that it spans the agendas of every Institute at NIH. Managing this complex and vast research portfolio requires a unique and unprecedented level of scientific leadership to determine research priorities and to ensure collaboration and minimize duplication in a united front against this devastating epidemic. The creation of the OAR has meant that there is now a single entity solely devoted to directing and coordinating the entire NIH AIDS research program. The consolidated appropriation also gives the OAR the opportunity to reassess resource allocations across the Institutes based on scientific developments that may occur after the budget is developed.

The FY 1997 budget includes $1.4 billion for AIDS-related research. This is an increase of 1.7 percent over FY 1996. The requested net $24 million increase for AIDS represents an additional $53 million for the support of investigator-initiated research projects and small business grants, with a $29 million decrease in the research contracts, intramural research, other research, and administrative support mechanisms. This emphasis on investigator-initiated basic research will allow for a broader search and assessment of the HIV/AIDS disease itself, which is needed at this time before major new advances in AIDS treatments and vaccines are likely to occur. Fundamental research on AIDS is also expected to have a significant impact on research in non-AIDS areas as well, as NIH focuses on better integrating behavioral and biomedical research programs related to AIDS. Similarly, the construction of

the new Clinical Research Center is also expected to greatly benefit AIDS research; approximately ten percent of research conducted in the current outdated Clinical Center is related to AIDS.

Other Research Mechanisms

In FY 1997, NIH plans to increase spending for research training by $10 million over FY 1996, a 2.4 percent increase. This will allow NIH to support 14,749 individual and institutional full-time research training positions. Within this increase, NIH will provide a 2.2 percent across-the-board stipend increase, the first stipend increase since FY 1994.

All other research mechanisms, excluding research project grants and training, are being held nearly constant in FY 1997, compared to FY 1996. Research centers are increasing only 0.5 percent, intramural research is decreasing 0.1 percent, and research contracts are decreasing 0.9 percent, all reflecting NIH's emphasis on investigator-initiated research project grants in the FY 1997 budget. Research management and support costs are generally being maintained at the reduced FY 1996 levels.

NIH OVERVIEW (by Institute/Center)

(Dollars in millions)

	1995 Actual	1996 Policy	1997 Request	Request +/- Policy
Institute:				
NCI	$1,913	$2,025	$2,060	+$35
NHLBI	1,243	1,298	1,321	+23
NIDR	163	171	175	+4
NIDDK	725	760	773	+13
NINDS	628	658	671	+13
NIAID	537	573	584	+11
NIGMS	880	921	937	+16
NICHD	509	534	543	+9
NEI	292	305	310	+5
NIEHS	266	283	289	+6
NIA	432	452	462	+10
NIAMS	228	239	243	+4
NIDCD	167	175	179	+4
NIMH	541	568	578	+10
NIDA	290	305	312	+7
NIAAA	180	188	192	+4
NINR	48	51	52	+1
NCRR	287	322	309	-13
NCHGR	153	169	178	+9
FIC	15	16	16	0
NLM	136	149	154	+5
OD	214	234	227	-7
OAR	1,334	1,408	1,432	+24
Third Party Reimbursements	0	0	18	+18
Subtotal	$11,181	$11,804	$12,015	+$211
B&F	114	146	420	+274
Subtotal, Program Level	$11,295	$11,950	$12,435	+$485
Offsets:				
NLM User Fees	-$11	-$11	-$11	$0
Third Party Reimbursements	0	0	-18	-18
Total, BA	$11,284	$11,939	$12,406	+$467
FTE	15,474	15,474	15,474	0

NIH OVERVIEW (by Mechanism)

(Dollars in millions)

	1995 Actual	1996 Policy	1997 Request	Request +/- Policy
Mechanism:				
Research Project Grants	$6,046	$6,420	$6,586	+$166
[No. of Non-competing].....	[17,069]	[18,047]	[18,573]	[+526]
[No. of New/Competing]	[6,858]	[6,620]	[6,827]	[+207]
[Total No. of Grants]....	[23,927]	[24,667]	[25,400]	[+733]
SBIR/STTR Grants	$173	$186	$229	+$43
Centers	1,006	1,038	1,044	+6
Research Training	381	395	405	+10
R&D Contracts	723	771	764	-7
Intramural Research	1,241	1,300	1,297	-3
Research Management/Support .	519	481	482	+1
Nat'l Library of Medicine (NLM)	139	152	157	+5
Office of the Director	239	261	252	-9
Women's Health Study [non-add]	[57]	[57]	[57]	[0]
Minority Health Study [non-add]	[58]	[63]	[63]	[0]
Other Research	714	800	781	-19
Buildings and Facilities	114	146	420	+274
Third Party Reimbursements	0	0	18	+18
Subtotal, Program Level	$11,295	$11,950	$12,435	+$485
Offsets:				
NLM User Fees.....	-$11	-$11	-$11	$0
Third Party Reimbursements	0	0	-18	-18
Total, BA	$11,284	$11,939	$12,406	+$467
FTE	15,474	15,474	15,474	0

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Program Level/BA	$2,195	$1,854	$2,098	+$244
Outlays	2,444	2,105	2,024	-81
FTE	649	649	649	0

* Based on levels of the ninth CR, including an incremental policy adjustment.

Summary

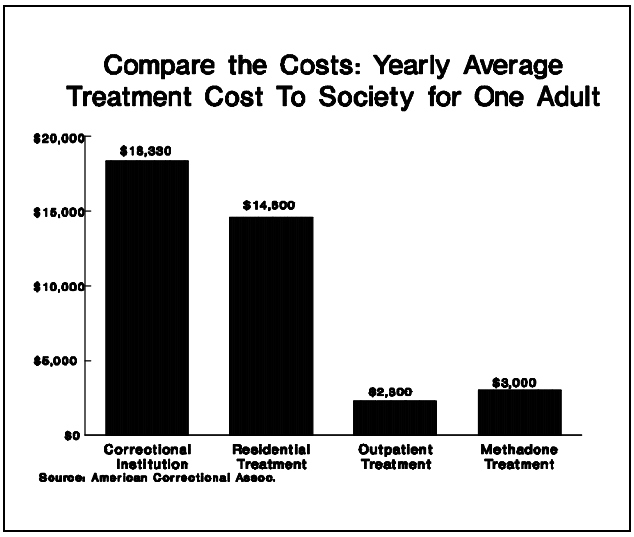
The FY 1997 budget request for the Substance Abuse and Mental Health Services Administration (SAMHSA) totals $2.1 billion. This request will provide important substance abuse and mental health services to thousands of pregnant women and their children, high risk youth, and other underserved Americans. SAMHSA is the Department's lead agency for mental health and substance abuse treatment and prevention. Given the heightened attention to the drug abuse prevention and treatment needs in the country, SAMHSA has devoted considerable effort to identify the most effective and efficient treatment and prevention programs and disseminate that knowledge to the States through the Substance Abuse Performance Partnership Block Grant.

The FY 1997 budget continues to pursue State Performance Partnerships in the mental health and substance abuse areas. While similar in concept to the current block grant program, the Performance Partnerships will require fewer earmarks, increase State flexibility, and increase emphasis on outcomes. In addition, SAMHSA will provide support to a wide array of demonstration efforts through the Knowledge Development and Application (KDA) program. New focuses in FY 1996 and FY 1997 will include: managed care, early childhood, emerging issues, co-occurring disorders, criminal justice, changing systems, and practice standards and guidelines.

Making Substance Abuse Prevention and Treatment Work

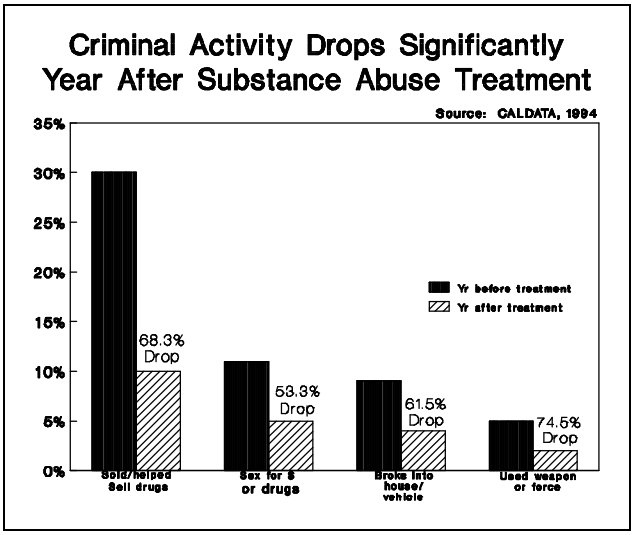
The annual cost of substance abuse in the United States--in terms of unnecessary health care, extra law enforcement activity, auto crashes, crime, and lost productivity--is more than $166 billion. The chronic drug user accounts for the bulk of illicit drugs consumed, and is a significant contributor to crime and violence. These statistics are indicative of a compelling need to identify effective and efficient approaches to address the nation's most costly public health problems. To respond to this crisis, SAMHSA's FY 1997 budget focuses on the

treatment of substance abusers--with a special focus on groups which use a significant share of treatment resources, contribute disproportionately to the societal costs of drug abuse, and for whom little improvement has been made.



The FY 1997 request for substance abuse prevention and treatment totals $1.6 billion. This includes $1.3 billion for the Substance Abuse Performance Partnership Block Grant. This program will give States maximum flexibility to develop treatment systems that ensure access, quality, and improved outcomes for substance abusers, particularly in areas of high incidence and prevalence. The FY 1997 request also provides a total of $352 million for substance abuse prevention and treatment demonstration activities. New funding for treatment demonstrations will address issues that enhance access to drug treatment through managed care, client and family-oriented substance abuse services, and effective drug treatment.

SAMHSA funded programs have had great success at minimizing the costs to society as a result of effective and efficient treatment and prevention services for substance abusers. For example, SAMHSA's Center for Substance Abuse Treatment (CSAT) has used discretionary grants to support a range of programs that have shown results. In California, a study of treatment effectiveness showed significant decreases in criminal activity after treatment for alcohol and other drug abuse disorders: $7.14 in savings for every dollar invested in treatment. In Colorado, a follow-up study found that of the clients who had been arrested in the two years prior to treatment admission, 94 percent had not been rearrested for driving under the influence and about 80 percent had no arrests for other offenses during the follow-up period. Finally, the Miami Coalition for a Drug Free Community used SAMHSA funds to support collaboration between law enforcement and family/neighborhood task forces that were instrumental at reducing crime by 24 percent, making over 8,000 arrests, and identifying and destroying crack houses.



Mental Health Services

SAMHSA's FY 1997 budget request of $419 million supports the Federal Government's role in the generation of knowledge and dissemination of research results on improving access to quality mental health services. The FY 1997 request maintains most Center for Mental Health Services (CMHS) programs at the FY 1995 enacted level. Included in the request is $275 million for the Mental Health Performance Partnership Block Grant. Most of the funding will be used to support existing grants. An additional $10 million over the FY 1995 enacted level is requested to fund FY 1997 Knowledge Development and Application (KDA) activities relating to mental health.

Future Plans--Managed Care Initiative

In 1995, nearly 60 percent of Americans (107 million) with private health insurance were enrolled in some type of specialty managed behavioral health program. States are moving aggressively to place large numbers of persons who have no private health insurance into mandatory managed care plans. For persons with mental illness and substance abuse disorders, the rapid growth of managed care is profoundly altering the public and private substance abuse and prevention system. The extent and impact of these changes has not been measured.

In 1997, SAMHSA will continue to expand a managed care initiative to address the needs and concerns of the mentally ill and those with substance abuse problems. SAMHSA will target at least $20 million of FY 1997 Knowledge Development and Application (KDA) funding resources to managed care issues. These initiatives include: improving quality, monitoring and reporting; establishing quality and performance measures; strengthening public-private partnerships; improving consumer information; streamlining administrative processes; and enhancing programs geared toward the special needs of this vulnerable population.

Studies within the publicly funded managed care network have shown signs of some success. For example, the Massachusetts Medicaid program has reduced costs by 22 percent below projections, based on past experience. The managed care vendor achieved savings by diverting hospital admissions to outpatient care, and by negotiating substantial price reductions with hospitals. For persons with substance abuse disorders, inpatient hospital treatment was cut by 61 percent, while treatment in freestanding detoxification centers, methadone counseling, and dosing increased substantially. The challenge here is to ensure that the goals of quality and access are not sacrificed and savings are achieved through a managed care system.

SAMHSA OVERVIEW

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Substance Abuse:				
Prevention KDA	$238	$106	$176	+$70
Treatment KDA	216	106	176	+70
Performance Partnership Grant	1,234	1,205	1,272	+67
Treatment Capacity Expansion	7	0	0	0
Subtotal, Substance Abuse	$1,695	$1,417	$1,624	+$207
Mental Health:				
Mental Health KDA	$52	$37	$62	+$25
Training and AIDS Training	1	1	0	-1
Children's Mental Health	60	59	60	+1
Performance Partnership Grant	275	264	275	+11
Homeless PATH Grants	29	0	0	0
Protection and Advocacy	22	20	22	+2
Subtotal, Mental Health	$439	$381	$419	+$38
Program Management	$61	$56	$55	-$1
Forfeiture Fund (non-add)	*(14)*	*0*	*0*	*0*
Total, BA	$2,195	$1,854	$2,098	+$244
FTE	649	649	649	0

* Based on levels of the ninth CR, including an incremental policy adjustment. The Policy Level also reflects the $200 million transfer proposed by the Senate from the Safe and Drug Free Schools Act program of the Department of Education for youth substance abuse prevention programs in schools and communities.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Program Level	$159	$126	$144	+$18
Budget Authority	141	80	90	+10
Outlays	139	129	97	-32
FTE	267	267	267	0

* Based on levels of the ninth CR, including an incremental policy adjustment.

Summary

The FY 1997 request for the Agency for Health Care Policy and Research (AHCPR) provides a program level of $144 million. Consistent with a Department-wide HHS Survey Integration Plan, AHCPR will fully fund the Medical Expenditure Panel Survey (MEPS)--replacing the National Medical Expenditure Survey (NMES)--at $45 million, as well as continue to fund its highest priority ongoing research commitments.

AHCPR directly contributes to improving the management of this nation's health care enterprise. Results of its health services research and clinical practice guidelines are used every day by health care providers working to improve quality of care while managing the financial bottom line. Its data collection and analysis are important to health policy analysis and help guide the decisions made by those steering the future of this nation's health care industry.

AHCPR works in partnership with the private sector in determining which medical interventions work best and provide the most value for our health care dollar in the day-to-day practice of medicine. In addition, AHCPR research addresses the effectiveness and cost-effectiveness of the organization, financing, and delivery of health services.

Research on Health Care Outcomes and Quality

The FY 1997 request for the Research on Health Care Outcomes and Quality program (HCOQ), formerly the Medical Treatment Effectiveness program (MEDTEP), is $48 million. At this level, AHCPR will continue to fund high priority continuation projects in outcomes research, particularly for conditions prevalent in the Medicare and Medicaid populations. HCOQ research helps consumers and providers make more informed choices about health

care. Part of that effort is to first determine what works in clinical practice through outcomes and effectiveness research and then educate consumers and providers on research results, particularly through the clinical practice guidelines program.

To cite a recent example of outcomes research, a grant to Duke University showed appropriate anticoagulant therapy could prevent strokes and save $600 million annually, cutting the number of strokes each year from 80,000 to 40,000. Implementation of AHCPR findings in just 20 percent of patients for the following conditions could save health care costs as follows (1996-2002): acute low back pain ($1.2 billion); stroke prevention ($832 million); prostate disease ($770 million); and acute pain management ($599 million).

Other HCOQ research includes:

- ..... Emergency Department Triage for Suspected Acute Cardiac Ischemia (ACI): Some 3.5 million of the 7 million people with ACI's who present to emergency departments annually are hospitalized, yet 50 percent of those are found not to have ACI and another 7 percent are sent home erroneously. This multi-center prospective controlled clinical trial will evaluate the potential of scanning aids to improve the accuracy of diagnosis of ACI.

- ..... Pediatric Asthma Care: This two-stage randomized controlled clinical trial is assessing the cost-effectiveness of comprehensive intervention for pediatric and adolescent asthma patients. The major outcomes to be measured include cost, functional status, results of pulmonary function tests, and changes in medication use.

- ..... Pelvic Inflammatory Disease (PID): This project is testing the most effective treatment approach for PID. This condition affects more than one million women a year and can result in infertility, ectopic pregnancies, and chronic pelvic pain. The cost of treating PID and its complications is estimated at $4 billion annually.

- ..... Strategies for Care of the Very Low Birthweight Infant: Neonatal intensive care has been the main reason for reduced infant mortality, but with success has come escalating medical treatment costs and increasing burdens of long-term functional impairments and disabilities. This study, which is scheduled for completion in 1997, addresses the outcomes, costs, and utilities of neonatal intensive care.

Improved methodologies have been developed for the second round of Patient Outcomes Research Teams (PORT II). Areas of research in FY 1997 include the care, cost and outcomes of local breast cancer and improving the cost-effectiveness of care for depression.

Pharmaceutical outcomes research projects will be continued in FY 1997, and will study the efficacy and cost-effectiveness of prescription drugs and related pharmaceutical interventions for treating clinical conditions. One recent example of this research is a grant to Vanderbilt School of Medicine that showed requiring prior authorization from the Tennessee Medicaid program in order to prescribe more costly arthritis medication saved $12.8 million over two years, without causing the substitution of other, more toxic drugs or increased use of medical services.

During FY 1997, AHCPR will support seven Research Centers on Minority Populations, focusing on which clinical strategies are best for clinical conditions with the greatest prevalence among African-Americans, Latinos, Asian and Pacific Islanders, American Indians, and/or Alaska Natives. Conditions being studied include high blood pressure, kidney disease, tuberculosis, low birthweight, substance abuse, and certain cancers.

AHCPR's clinical practice guidelines program enhances the quality, appropriateness, and effectiveness of health care. AHCPR has arranged for the development of 22 science-based clinical practice guidelines that address some of the most significant health care problems facing Americans. Seventeen of these guidelines have been released ranging in subject from treatment of acute postoperative pain to cardiac rehabilitation. This month AHCPR released an update of the Urinary Incontinence in Adults guideline, which reaffirms the work of the 1992 panel and shows that urinary incontinence is treatable and those afflicted need not suffer in silence. AHCPR's guidelines not only reduce medical treatment uncertainty, they can directly benefit consumers and medical practitioners by improving patient outcomes and quality of life. The guidelines can also benefit the nation by eliminating or reducing the use of medical tests and therapies that do not work or are unnecessary.

Research on Health Care Systems Costs and Access

The FY 1997 request includes $49 million for the Health Care Systems Cost and Access program (HCSCA), formerly the Research on Health Care Costs, Quality and Access program. HCSCA research develops the analyses and tools needed to improve the functioning of the health care system. At this level, AHCPR will fund high priority continuation projects in a variety of areas, including consumer decision making; the health care marketplace; primary care; managed care; rural health services; and AIDS health services.

AHCPR will continue to support a major initiative to assist consumers in selecting high quality health plans and services, the Consumer Assessments of Health Plans Study (CAHPS). Surveys by objective, non-government polling firms have shown that most Americans would like to have more information to help them choose hospitals, doctors, and health care plans. CAHPS brings together the nation's top experts in patient satisfaction and survey research to develop and test the best methods for measuring consumers' satisfaction with their health plans and methods for getting the results to consumers.

Also, research on market forces in a changing health care system will be sustained. These projects are examining how changes in the structure of defined markets have affected the way health care providers produce and deliver care and the price, distribution, and quality of services available.

The request will maintain support for research on primary care, the most frequent site of health care delivery, and the source of most referrals to secondary and tertiary care. Examples of primary care research include a study testing the effect of an interactive CD designed to decrease cervical cancer by improving the frequency and quality of screening for patients in community health centers.

Managed care research supported by AHCPR provides a greater understanding of the rapid financial and organizational changes occurring in the U.S. health care system. An example of managed care research underway is a study showing that managed care patients spent two fewer days in an intensive care unit than patients with fee-for-service health insurance, with the average stay for managed care patients costing $8,000 less, with no difference in mortality or ICU readmission between the two groups.

AHCPR will continue to fund five specialized centers for rural health services demonstrations in Iowa/Nebraska, Maine, West Virginia, Arizona, and Oklahoma. AHCPR also will continue to support the HIV Cost and Services Utilization Study (HCSUS), a large-scale study that provides vital information on costs and services resulting from health care delivery to the HIV-infected persons.

Health Insurance and Expenditure Survey

The FY 1997 request includes $45 million, an increase of $30 million over FY 1996, to support the second year of the Medical Expenditure Panel Surveys (MEPS). This investment will fund costs associated with the move from the development phase and early data collection phase of the surveys to the full data collection phase. The field work for the household and nursing home surveys started in FY 1996. In FY 1997, these surveys both continue with the household survey intensifying, plus the health insurance plans survey, the medical provider plan survey, and the national health insurance survey will all start data collection. During the full data collection phase, all five surveys will be in the field where extensive interviews are conducted by employing such innovations as computer assisted personal surveys that will greatly improve the timeliness of MEPS results. Early access to data for analysis will allow health care policy makers to base decisions on more current information than has been available in the past.

No surveys other than MEPS provide the Federal Government or the private sector with detailed information regarding the health care services used by American families and individuals; the cost, scope, and breadth of private health insurance coverage held by and available to the U.S. population; and the specific services that are purchased through out-of-pocket and/or third-party payments. This information is essential for developing national and regional estimates of the impact of changes in financing, coverage, and reimbursement policy, and estimates of who benefits and who bears the cost of a change in policy.

Under the Department's Survey Integration Plan, important linkages with other HHS surveys have been established that will help keep survey costs lower than originally projected--and improve data collection and analysis of health care expenditures and health insurance in the U.S. MEPS builds upon the strengths of the 1977 and 1987 National Medical Expenditure Survey (NMES) and streamlines the Department's data collection efforts. Unlike NMES, which developed its own large sampling frame of families to interview, MEPS relies upon an existing nationally representative sampling frame developed by the National Center for Health Statistics (NCHS) and eliminates duplication that existed with the Health Care Financing Administration (HCFA) in surveying the over-65 population. MEPS also incorporates and links the National Health Interview Survey (NHIS) with the survey components of MEPS.

MEPS, which began in FY 1994, will now include a national employer health insurance survey component. The purpose of the employer health insurance survey is to obtain national and state-specific estimates of the availability of health insurance at the workplace, type of coverage provided by employers, and the associated costs of coverage.

Analytical work on the data collected will begin in FY 1997 and is expected to be complete by FY 2001. As part of the Department's Survey Integration Plan, MEPS will no longer be a periodic annual survey. Instead it will be converted to an ongoing continuous survey--resulting in a continuous resource for those dependent on these data to manage this nation's health care industry. Over time, MEPS will provide more comprehensive data for public and private sector decision makers.

AHCPR OVERVIEW

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Research on Health Care Outcomes and Quality	$80	$55	$48	-$7
Research on Health Care Systems Cost and Access...	62	54	49	-5
Health Insurance & Expenditure Survey	15	15	45	+30
Program Support.....	2	2	2	0
Subtotal, Program Level.....	$159	$126	$144	+$18
Less Transfers: PHS Intra-agency....	-18	-46	-54	-8
Total, BA	$141	$80	$90	+$10
Medicare Trust Funds [Non add]....	[6]	[3]	[6]	[+3]
FTE	267	267	267	0

* Based on levels of the ninth CR, including an incremental policy adjustment.

HEALTH CARE FINANCING ADMINISTRATION

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Budget Authority	$262,272	$285,566	$320,107	+$34,541
Outlays**	248,920	272,475	295,675	+23,200
FTE	4,100	4,100	4,100	0

* Based on levels of the ninth CR, including an incremental policy adjustment.
** Includes non-HCFA administrative costs, and is net of offsetting receipts.

Summary

The FY 1997 budget request for the Health Care Financing Administration (HCFA) is $296 billion (net of offsetting receipts) for Medicare and Medicaid benefits and operating costs, an increase of $24 billion over FY 1996 (see Figure 1 for the distribution of spending). Spending for the Medicare and Medicaid programs represents 84 percent of the total HHS budget for FY 1997.

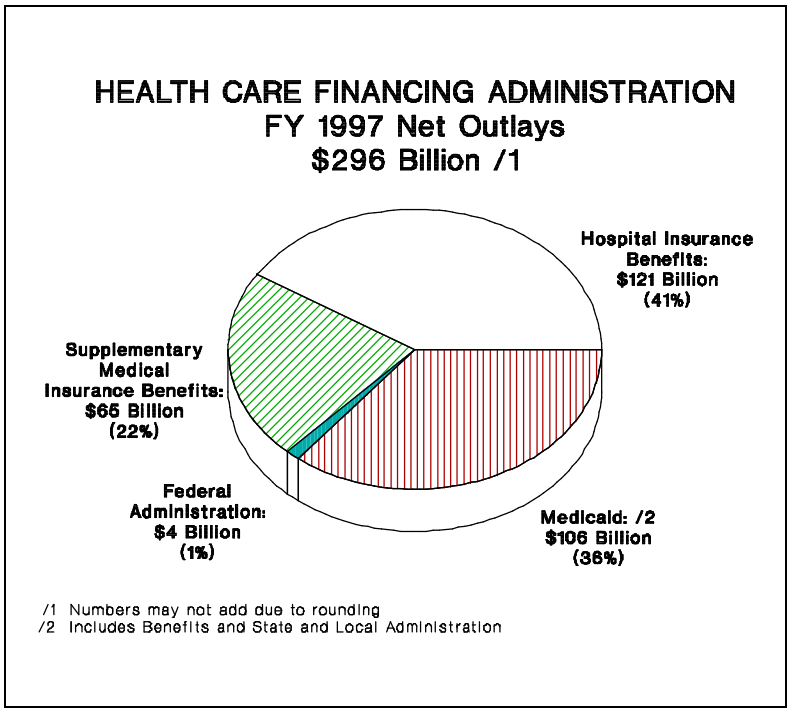


Figure 1

The Medicare and Medicaid budget includes legislative proposals that reduce spending by $3 billion in FY 1997. Medicare and Medicaid combined will pay for the health care costs of approximately 72 million elderly, disabled and economically disadvantaged Americans in FY 1997 (individuals eligible for both Medicare and Medicaid are not double counted in this figure). In FY 1997, the number of people served by these programs will increase by about 2 million, or 2.3 percent, over FY 1996. Slightly more than a quarter of all Americans will receive Medicare or Medicaid services in FY 1997.

MEDICARE

Summary

Medicare is a Federal health insurance program for people age 65 or older and people under age 65 who are disabled or suffer from end-stage renal disease (ESRD). In FY 1997, the program will serve approximately 38.1 million eligible individuals. Medicare consists of two parts:

- Part A--Hospital Insurance (HI)

  Pays for inpatient hospital care, certain inpatient care furnished in skilled nursing facilities, home health care and hospice care. The HI program is funded through the HI Trust Fund. The Fund receives most of its income from the HI payroll tax (2.9 percent of payroll, split between employers and employees).

- Part B--Supplementary Medical Insurance (SMI)

  Pays for medically necessary physicians' services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment and certain other medical services and supplies. The SMI program is funded through the SMI Trust Fund. The Fund receives income primarily from two sources: a general revenue transfer and premiums paid by enrollees.

Total Medicare benefit outlays in FY 1997, including the effect of legislative proposals, are estimated at $206 billion, 6.6 percent higher than FY 1996 estimated benefit outlays. This increase in outlays reflects projected growth in beneficiary enrollment, service utilization and inflation.

Strengthening Medicare

The President's Medicare plan strengthens and improves the program, reducing spending by a net $124 billion over seven years and guaranteeing the solvency of the trust fund for more than a decade. Specific reforms give seniors more choices among private health plans, make Medicare more efficient and responsive to beneficiary needs, attack fraud and abuse through programs praised by law enforcement officials, cut the growth rate of provider payments, and hold the Part B premium at 25 percent of program costs.

Provider Payment Reforms and Program Savings

- **Hospitals:** The budget reduces the annual inflation increase or "update" for payment for inpatient care and adjusts payments for capital. It also reforms the payment method for outpatient departments while protecting beneficiaries from increasing charges for those services.

- **Managed Care:** The budget reforms payments by using reasonable rate-of-growth

limits on updates for managed care payments and reducing the current geographic variation in payments.

- **Physicians:** The budget reforms physician payments by paying a single update for all physicians and replaces current "volume performance standards" with a sustainable growth rate.

- **Home Health Care/Skilled Nursing Facilities:** The budget implements a series of interim payment reforms before the establishment of fully prospective payment systems for home health care and skilled nursing facilities.

- **Fraud and Abuse:** The budget introduces aggressive and comprehensive policies to help stamp out Medicare waste, fraud, and abuse, and extends and enhances Medicare secondary payor policy to ensure that Medicare pays only when it should.

- **Other Providers:** The budget freezes updates for durable medical equipment and ambulatory surgical centers and reduces payments for oxygen.

- **Beneficiaries:** The budget continues, but does not increase, the requirement that beneficiaries pay 25 percent of Part B costs.

Provisions to Improve Rural Health Care

The President's plan enhances access to, and the quality of, health care in rural areas. To do so, it extends the Rural Referral Center program, directs Medicare reimbursement for nurse practitioners and physician assistants, improves the Sole Community Hospital program, and expands the Rural Primary Care Hospital program and provides grants to promote telemedicine and rural health outreach.

Program Improvements that Expand Choices and Add Preventive Benefits

The President's plan transforms the traditional fee-for-service program from a bill-paying insurance program into a responsive health plan by giving Medicare authority to adopt many of the purchasing and quality techniques pioneered by private sector payors.

The budget also expands and improves Medicare managed care by:

- ensuring beneficiary protections while increasing the types of plans--including Preferred Provider Organizations (PPOs) and Provider Sponsored Networks (PSNs)--available to seniors; and

- instituting a coordinated open enrollment process--similar to that used by the Federal Employees Health Benefits Plan (FEHBP)--during which beneficiaries use comparative information to choose among managed care and supplemental insurance options.

In addition, the budget expands coverage of preventive benefits to include annual

mammograms and the elimination of mammography coinsurance, colorectal cancer screening, and increased payments for flu shots. Finally, the budget introduces a respite care benefit to provide some relief for families caring for relatives with Alzheimer's disease.

Medicare Baseline

The President's budget estimates that Medicare benefits will be $1.6 trillion from 1997-2002. This represents a decrease in the estimate of $5.3 billion over the six years compared to Mid-Session Review (MSR), a drop of 0.3 percent. However, this reflects an increase of $37 billion in Hospital Insurance (HI or Part) balanced by a decrease of $42.3 billion in Supplementary Medical Insurance (SMI or Part B). While economic changes brought the estimate for Medicare spending down from the MSR, technical changes worked in the opposite direction to increase the estimate of outlays.

- The $7 billion upward **technical** re-estimate for the period 1997-2002 was comprised of the following baseline adjustments:

  - The estimated Part A increase of $41.4 billion hinged on higher projected outlays for inpatient services, skilled nursing facility services, and home health services. The largest estimated increase, both in percentage and actual dollars, occurred in home health services, with a technical increase of over $27 billion. The increases were partially offset by a lower estimate for hospice services, which dropped about $8 billion.

  - The estimated Part B technical decrease of $34.3 billion largely offset the Part A increase. The Part B decrease was comprised of lower spending projections for physician, outpatient, and group practice outlays. Estimates for both independent labs and Part B home health outlays increased by a small amount.

- The **economic** decrease of $12.3 billion for the period 1997-2002 incorporated the following baseline adjustments:

  - In Part A, new economic assumptions decreased the baseline by $4.4 billion due to decreases in growth assumptions for wages and prices.

  - In Part B, new economic assumptions decreased the baseline by $7.9 billion, due almost solely to anticipated decreases in the Medicare economic index. This index is also sensitive to changes in wages and prices.

MEDICARE OVERVIEW

(Beneficiaries in millions)

	1995	1996	1997	+/-
Persons Enrolled:				
Hospital Insurance (HI Part A)	36.9	37.5	38.1	+0.6
Supplementary Medical Insurance (SMI Part B)	35.5	36.0	36.5	+0.5

(Outlays in millions)[1]

	1995 Actual	1996 Policy	1997 Request	Request +/-Policy
Current Law:				
HI Benefits	$113,403	$124,841	$136,799	+$11,958
SMI Benefits (including ESRD)	63,482	69,055	76,287	+7,232
Peer Review Organizations	190	268	270	+2
Subtotal, Med. Ben. w/PROs	$177,075	$194,164	$213,356	+$19,192
HCFA Admin/Research	$2,109	$2,137	$2,191	+$54
Intergovernmental Transfer	--	$319	--	-319
SSA/Non-HCFA Admin	913	968	1,009	+41
Subtotal, Admin.	$3,022	$3,424	$3,200	-$224
Total, Current Law Outlays	$180,097	$197,588	$216,556	+$18,968
Proposed Legislation:				
Part A Savings	--	-$151	-$14,184	-$14,033
Part B Savings	--	-10	7,734	7,744
Total, Outlays, Net Proposed Law	$180,097	$197,427	$210,106	+$12,679
Offsetting Receipts	-$20,242	-$19,842	-$20,287	-$445
Effect of P.L. on Offsetting Receipts[2]	--	--	288	+288
Total, Net Outlays[3]	$159,855	$177,585	$190,107	+$12,522

1 Numbers may not add due to rounding.

2 Offsetting receipts include premiums collected from beneficiaries under Medicare Parts A and B.

3 Total Net Medicare Outlays equal current law outlays minus the impact of proposed legislation and offsetting receipts. Total does not include the Clinical Laboratory Improvement Amendment (CLIA) or the HMO Loan Fund.

MEDICAID

Summary

In FY 1997, Medicaid will provide grants to States for the medical care of about 39 million low-income individuals. The Federal share of Medicaid payments is expected to reach $102 billion. This is a $7.4 billion (7.8 percent) increase over projected FY 1996 spending. The President has recently submitted a comprehensive Medicaid reform package, which streamlines the program while preserving the guarantee of health and long-term care coverage for the most vulnerable Americans.

Enhancing State Flexibility

States have considerable flexibility in structuring the Medicaid programs, including determining provider payment rates, certification standards, and developing alternative health care delivery programs. In addition, waivers from various portions of the broad Federal guidelines are also available to States.

Freedom-of-choice waivers allow States to implement cost-effective systems of care, such as case management and competitive bidding arrangements. Home and community-based service waivers allow States to cover community-based care as an alternative to institutionalization.

States have also begun to restructure eligibility and coverage under Medicaid through the use of Section 1115 demonstration waivers. Under these demonstrations, States acquire savings by incorporating managed care concepts, redirecting uncompensated care payments, and consolidating State health programs. States use these savings to expand coverage to previously uninsured populations. States are using Section 1115 waivers to reform health care by expanding coverage without increasing the amount the Federal Government would have otherwise spent. Since 1993, this Administration has approved twelve Section 1115 demonstrations, and is committed to working cooperatively with additional States to support innovative ideas. Delaware, Vermont, Hawaii, Oregon, Tennessee, Minnesota, Oklahoma[1], and Rhode Island are currently operating approved demonstrations, extending health care coverage to about 672,000 Americans who were otherwise not covered by health insurance. Florida, Kentucky, Massachusetts, and Ohio have approved waivers but have not begun operation of their demonstrations. Once fully implemented, these twelve demonstrations could extend coverage to 2.2 million individuals, at no increased cost to the Federal Government.

Legislative Proposal

The President's plan for Medicaid reforms the program but preserves the guarantee of health and long-term coverage for the most vulnerable Americans. It saves $59 billion over seven years responsibly, by limiting spending on a per-person basis (a "per capita cap") and reducing

[1] Oklahoma has no expansion population in its 1115 waiver.

Disproportionate Share Hospital payments and retargeting them to hospitals that serve large numbers of Medicaid and uninsured patients.

The plan provides special payments for States to transition into the new system, and to meet the most pressing needs. It also gives States unprecedented flexibility to administer their programs more efficiently. Finally, this plan retains current nursing home quality standards and continues to protect the spouses of nursing home residents from impoverishment.

The President's Medicaid reform proposal would also give States more flexibility in managing their Medicaid programs. Changes include:

- **Boren Amendment**: The plan repeals the so-called "Boren amendment," eliminating Federal provider payment requirements for hospitals and nursing homes.

- **Managed care**: The plan allows States to enroll beneficiaries in managed care without Federal waivers.

- **Home- and community-based care**: The plan allows States to provide services in home- and community-based settings to people who need long-term care without having to seek Federal waivers.

- **Coverage expansions without waivers**: The plan enables States, without waivers, to expand coverage to any person in a family with income less than 150 percent of the Federal poverty line.

Background

Medicaid is a voluntary program, initiated and administered by the States. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average. Current matching rates for FY 1996 are projected to range from 50 to 77 percent for medical assistance payments and from 50 to 100 percent for administrative costs. The Federal matching rate on average is approximately 57 percent.

Most individuals' eligibility for Medicaid is based on qualifying under the cash assistance programs of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). All AFDC and most SSI recipients, commonly referred to as the "categorically eligible," are covered under State Medicaid programs. States cover some individuals not eligible for AFDC or SSI (e.g., higher income persons in institutions, low-income pregnant women and children, and aged, blind and disabled persons below the poverty line). States may also cover "medically needy" individuals. Such persons would meet the categorical eligibility criteria, but have too much income or resources. By incurring medical expenses, these persons may spend down to the medically needy standard.

States are required to provide a core of 13 services to all eligible recipients. Those mandatory Medicaid services include inpatient and outpatient hospital care, health screening, diagnosis and

treatment to children, family planning, physician services and nursing facility services to individuals over 21. States may also elect to cover any of over 30 specified optional services, which include prescription drugs, clinic services, and services provided in intermediate care facilities for the mentally retarded.

Medicaid covers children under the age of six and pregnant women whose family income does not exceed 133 percent of the Federal poverty level. Medicaid coverage of children aged 6 through 18, born after September 30, 1983, whose family income does not exceed 100 percent of the Federal poverty level, is being phased in. By 2002, all children under the age of 19 living below the poverty level will be covered by Medicaid. In addition, Medicaid pays Medicare premiums and cost sharing for Medicare coverage of certain poor seniors and disabled individuals eligible for Medicare, also referred to as Qualified Medicare Beneficiaries (QMBs). The President's Medicaid reform proposal would preserve these important protections and expansions.

Federal Medicaid outlays rose dramatically from FY 1989 through FY 1992, at a 25 percent average annual rate. However, outlay growth slowed to less than 12 percent in FY 1993, followed by 8 percent growth in FY 1994. The decline in the rate of Medicaid increases is due to many factors, including legislative changes (such as Limits on Provider Specific Taxes and Donations), decreases in the projected growth of SSI caseloads, and States' efforts to control costs. The President’s plan maintains these appropriate limitations.

MEDICAID OVERVIEW

(Recipients in thousands)

	1995	1996	1997	+/-
Beneficiaries:*				
Aged 65 and Over	4,234	4,389	4,553	+164
Blind and Disabled	6,009	6,341	6,626	+285
Needy Adults	7,774	8,041	8,260	+219
Needy Children	17,574	18,169	18,659	+490
Other	576	576	576	+--
Unduplicated Total	36,168	37,516	38,674	+1,158

(Outlays in millions)

	1995 Actual	1996 Policy	1997 Request	Request +/-Policy
Current Law:				
Benefits	$85,194	$90,480	$97,653	+$7,173
State and Local Administration	3,491	3,965	3,927	-38
Vaccines for Children 185	213	469	+256	
Survey and Certification	137	154	163	+9
State Medicaid Fraud Control Units	63	79	82	+3
Total, Current Law*	$89,070	$94,892	$102,294	+$7,403

* Numbers may not add due to rounding.

PROGRAM MANAGEMENT

Summary

HCFA's FY 1997 Program Management budget request is $2,202 million, a 3.3 percent increase over estimated FY 1996. The Program Management account provides resources for administering the Medicare and Medicaid programs. Program Management supports the following activities: Medicare Contractors; Federal Administration; Medicare Survey and Certification; and Research, Demonstrations and Evaluation.

While workloads have continued to increase every year, the Program Management budget has remained relatively flat or decreased, requiring HCFA to find more efficient methods to accomplish its mission and its goals as established in its strategic plan. HCFA is attempting to fulfill a significant part of this mission with the development and implementation of the Medicare Transaction System (MTS), HCFA's state-of-the-art information management initiative. MTS will consolidate the current system of 77 claims-payment contractors utilizing nine shared computer systems into one system operated by three contractors using standardized data elements. This initiative will achieve substantial administrative savings through the use of new technology, consolidation of processing systems and standardized data. MTS will affect all aspects of Medicare, positioning HCFA to reengineer itself more productively for the challenging times ahead.

Medicare Contractors

The Medicare program is administered through private organizations, usually private insurance companies, which are referred to as contractors. Contractors' responsibilities include processing claims and making benefit payments, performing certain functions to ensure the appropriateness of Medicare payments and to protect the Medicare Trust Funds, developing management improvements called productivity investments, and responding to the needs of its many customers and stakeholders, the Medicare beneficiaries and the provider community.

Despite a growing investment in MTS and an increasing claims workload, the Medicare Contractor budget will increase by only 0.6 percent, from $1,604.2 million in FY 1996 to $1,614.2 million in FY 1997. The four key contractor activities are claims processing, beneficiary and provider services, payment safeguards and productivity investments.

Approximately 53 percent of the FY 1997 contractor budget request, or $849 million, has been designated for claims processing, a 2 percent decrease from FY 1996. HCFA's success in controlling processing costs has resulted in reduced unit costs of processing claims, allowing the agency to process an expected 861 million claims in FY 1997 within statutorily limited processing times. This workload level represents a 3.4 percent increase over revised FY 1996 estimates. HCFA anticipates that increased managed care enrollment will limit growth in claims and billings.

Beneficiary and provider services comprise 16 percent of the Medicare Contractors' FY 1997 request, or $254 million. This amount will maintain funding for the Medicare beneficiary

toll-free telephone lines, timely hearings and reconsiderations, prompt responses to provider and beneficiary inquiries, provider education and training efforts, and the Medicare participating physicians program. HCFA will continue its innovative use of audio response units (ARUs) for telephone inquiries, as well as continuing its use of the telephone to conduct hearing reviews and reconsiderations. These activities demonstrate HCFA's combined efforts toward more cost-effective management and a greater commitment to providing better customer service.

This request provides $396 million for payment safeguard activities to prevent and recover inappropriate Medicare payments, an amount virtually equal to that appropriated for the last three years. These activities include financial audits, medical and utilization reviews, and the identification of Medicare beneficiaries who have other insurance plans with primary responsibility for paying claims. Funds are also earmarked to support carrier efforts in detecting, developing and investigating program fraud and abuse. HCFA expects to generate $5.6 billion in savings to the Trust Funds with its $396 million investment in payment safeguard activities in FY 1997, a 14 to 1 return on investment.

Building upon the Department's current efforts in Operation Restore Trust to combat health care fraud and abuse, HCFA currently has legislation before Congress to provide a stable and reliable funding source for these activities under the direct spending budget. HCFA's long-term strategy to fund current Medicare payment safeguard activities is the Medicare Benefit Integrity System (MBIS). MBIS removes these activities from the discretionary account and moves them to the entitlement account, using Trust Fund dollars. Should this legislation be enacted, an additional $104 million would be added to the above amount to supplement HCFA's current effort.

The budget request allocates $115 million for productivity investments. Productivity investments enhance the cost-effectiveness and quality of contractor operations and are part of the long-term reform of Medicare administration. In FY 1997, HCFA will begin implementation of the Medicare Transaction System (MTS). MTS implementation will be completed in FY 1999. After that time, HCFA estimates that MTS will achieve $200 million in annual administrative savings. Other productivity investments costs include transition costs for contractors who may leave the program.

Federal Administrative Costs

For FY 1997, the President's budget requests $359 million for HCFA's Federal administrative costs. This request also includes a staffing level of 4,100 FTE. HCFA remains on target to meet the Department's FTE targets, thereby supporting the President's mandate on reducing the size of the Federal work force. This funding level also includes funding to support the extensive data processing requirements for the Medicare and Medicaid programs, as well as necessary maintenance and enhancement of 80 automated data systems. This funding level also allows HCFA $2 million for HCFA On-Line to continue activities to make the agency more responsive to providers and beneficiaries. HCFA will also spend $20 million to update and distribute the Medicare Handbook to all Medicare beneficiaries in FY 1997. HCFA will also fund its new Long-Term Care initiative in FY 1997. Activities to begin creating and

developing alternative long-term care models will be funded at $1 million in FY 1997.

Research, Demonstrations and Evaluation

The FY 1997 budget requests $55.3 million for the Research, Demonstrations and Evaluation program. HCFA's research program supports research and demonstration projects to develop and implement new health care financing policies and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, and our other customers and partners. Information from HCFA's research program is used by Congress, the Executive Branch, and States to improve the efficiency, quality, and effectiveness of the Medicare and Medicaid programs.

In addition to basic research, this budget fully funds the Medicare Current Beneficiary Survey and the Information, Counseling and Assistance Grants program. Basic research funds will support research and demonstration in the areas of monitoring and evaluating health system performance, improving health care financing and delivery mechanisms, meeting the needs of vulnerable populations, and improving consumer choice and health status. HCFA will continue its commitment to rural health needs in FY 1997 by supporting efforts for telemedicine demonstrations in rural areas.

Survey and Certification

Ensuring the safety and quality of care provided by health facilities is one of HCFA's most critical responsibilities. HCFA contracts with State agencies to inspect health facilities providing services to Medicare and Medicaid beneficiaries to ensure compliance with Federal health, safety, and program standards. HCFA's quality oversight includes initial inspections of providers who request participation in the Medicare program, annual recertification inspections of nursing homes and home health agencies (HHAs) as required by law, investigation of beneficiary complaints, and periodic recertification surveys of other health care providers and suppliers.

For FY 1997, the President's budget requests a total of $173.8 million for direct survey and certification activities and workloads. This $28 million increase over FY 1996 is necessary both to conduct initial inspections of more than 3,200 facilities expected to request Medicare participation (including the elimination of any prior year backlog), and to increase the frequency of annual surveys performed on non-long-term care facilities (e.g., ESRD facilities, hospices, rural health clinics, ambulatory surgical centers). As mandated by OBRA 87, HCFA conducts recertification surveys (over 24,000) on nursing facilities and home health agencies annually--a coverage level of 100 percent. HCFA plans to reach a recertification coverage level on non-accredited hospitals and psychiatric hospitals, hospices and other providers of 25 percent.

As part of the Health Care Quality Improvement Program, HCFA is currently placing greater emphasis on effective internal quality management systems within Medicare facilities, as well as the provider's responsibility to monitor outcomes. In FY 1997, HCFA will be retraining

surveyors across the country to reinforce our focus on patient outcomes, which will result in improved quality throughout the program.

Legislative Proposals

The President's health care legislation package provides added protections for individuals and small businesses and makes health coverage more accessible, portable, and affordable. The Health Insurance for the Unemployed proposal provides funds to States to finance up to six months of coverage for unemployed workers and their families. Other proposed insurance reforms restrict pre-existing conditions exclusions and prohibits lifetime benefit maximums or caps on benefits for specific conditions. A small State grant program will be established to accelerate the development of health insurance purchasing cooperatives, which have successfully reduced costs and increased choice for small businesses by allowing them to pool their employees for purposes of purchasing health insurance.

Clinical Laboratory Improvement Amendments of 1988

The Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes. CLIA '88 also introduced user fees for clinical laboratories to finance survey and certification activities. User fees are credited to the Program Management account but are available until expended for CLIA activities. The CLIA program is fully operational, with about 152,000 laboratories registered with HCFA; about 26 percent of the labs are subject to routine inspection under the program.

PROGRAM MANAGEMENT OVERVIEW

(Obligations in millions)[1]

	1995 Actual	1996 Policy	1997 Request	Request +/-Policy
Medicare Contractors:				
Claims Processing	$873	$869	$849	-$19
Bene./Prov. Services	269	268	254	-14
Payment Safeguards[2]	415	396	396	-
Productivity Investments	47	72	115	+43
Subtotal, Medicare Contractors	$1,604	$1,604	$1,614	+$10
Survey and Certification	146	146	174	+28
Federal Administration	354	328	359	+31
Research	75	55	55	-
Subtotal, BA (current law)	$2,178	$2,132	$2,202	+$70
CLIA	34	37	43	+6
Total, Program Level[3]	$2,353	$2,169	$2,245	+$76
FTE	4,100	4,100	4,100	0

1 Numbers may not add due to rounding.

2 The FY 1995 Appropriation for payment safeguard was $396 million.

3 Not included in these totals are the legislative proposals for the Medicare Benefit Integrity System (-$396 million from Payment Safeguards in FY 1997), for the Health Insurance for the Temporarily Unemployed (+$1,519 million in FY 1997), and for the state grants for health care purchasing cooperatives (+$25 million in FY 1997).

HCFA SUMMARY

(Outlays in millions)[1]

	1995 Actual	1996 Policy[2]	1997 Request	Request +/-Revised
Current Law:				
Medicare Benefits (includes PROs and ESRD)	$177,074	$194,164	$213,356	+$19,192
Medicaid Benefits	89,070	94,892	102,294	+7,402
HCFA Administration	2,109	2,137	2,191	+54
Other-HHS Administration	913	968	1,009	+41
Intergovernmental Transfer	--	319	--	-319
HMO Loan Fund	3	1	1	--
Total, Outlays Current Law	$269,169	$292,481	$318,851	+$26,369
Proposed Law:				
Medicare	--	-161	-6,450	-6,289
Medicaid	--	--	3,277	3,277
Program Management	--	--	--	--
Total, Outlays Net Proposed Law	$269,169	$292,320	$315,678	+$23,357
CLIA [Non-Add]	[30]	[36]	[42]	[+6]
Offsetting Receipts[3]	-20,242	-19,842	-20,287	-445
HMO Loan Fund	-7	-3	-3	--
Effect of P. L. On Offsetting Receipts	--	--	288	+288
Total, Net Outlays[4]	$248,920	$272,475	$295,675	+$23,200
FTE	4,100	4,100	4,100	0

1 Numbers may not add due to rounding.
2 Based on the levels of the ninth CR, including an incremental policy adjustment.
3 Offsetting receipts include premiums collected from beneficiaries under Medicare Parts A and B.
4 Total net outlays equal current law outlays minus the impact of proposed legislation and offsetting receipts.

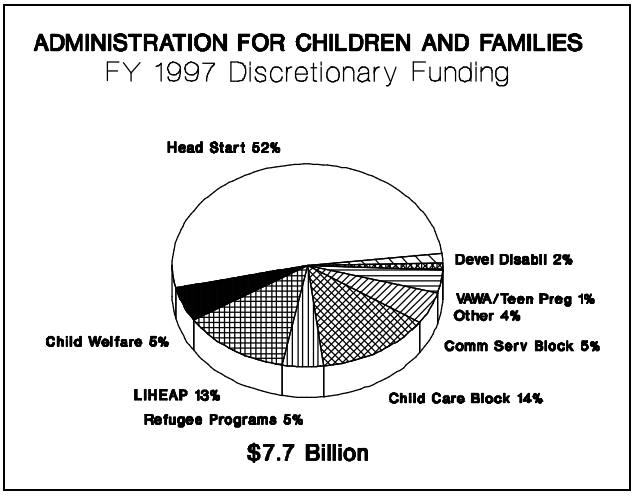
ADMINISTRATION FOR CHILDREN AND FAMILIES

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/- Policy
Program Level/BA:				
Discretionary.....	$7,649	$7,169	$7,710	+$541
Entitlement..	25,050	25,441	26,586	+1,145
Total.....	$32,699	$32,610	$34,296	+$1,686
Outlays:				
Discretionary.....	$7,829	$7,495	$7,361	-$134
Entitlement..	24,164	25,635	26,660	+1,025
Total.....	$31,993	$33,130	$34,021	+$891
FTE	1,803	1,803	1,803	0

* Based on levels of the ninth CR, including an incremental policy adjustment.

Discretionary Program Summary



The Administration for Children and Families (ACF) is the Department's lead agency for programs serving America's children, youth, and families. In FY 1997, ACF is seeking $7.7 billion for discretionary programs within ACF that promote healthy children, supportive families, and vibrant communities.

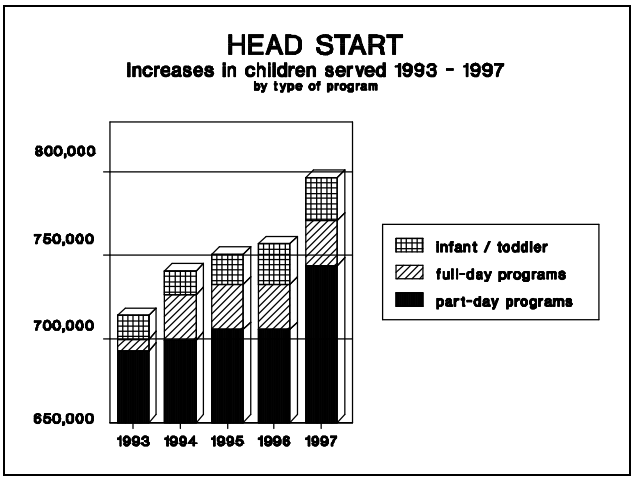
The Department has a strong commitment to ensuring that our nation's children and youth are healthy, safe, and developing to their full potential in stable families and secure communities. To better fulfill government's responsibility toward children and families, the Department has developed a multifaceted strategy that promotes strong futures. Secretary Shalala commissioned a Governing Council on Children and Youth and charged this group with increasing coordination and collaboration throughout the Department on program and policy issues affecting children. That collaborative strategy is also evident through investments in programs which support Strong Foundations--the building blocks of success for children and families--and Safe Passages--the

tools for navigating the transition from childhood to adulthood. Head Start, child care, and child welfare services emphasize early childhood health and development and promote Strong Foundations for our children. Equally important are the supports needed to ensure Safe Passages for the critical journey through adolescence. The Department is moving forward to launch and coordinate a wide array of activities to promote Safe Passages for our nation's youth including a teen pregnancy prevention initiative and the community schools program.

Head Start

Investing in Head Start and expanding enrollment are key Presidential priorities. The FY 1997 budget request of $3.98 billion for Head Start will serve an additional 46,000 children. This request, an increase of $447 million over FY 1995, will establish strong foundations for a total of 796,500 children and their families. As a result of this Presidential investment, Head Start will grow to serve over one million children by the year 2002.

Head Start continues to be one of the nation's most successful programs for low-income children and families, providing comprehensive education, nutrition, health services and social services. Evaluations of Head Start children continue to show that the Head Start experience has a positive impact on school readiness, increases children's cognitive skills, self-esteem, and achievement motivation, and improves school social behavior. Head Start also helps to improve the parenting skills and employment related skills of Head Start parents.



Important funding increases sought by the Clinton Administration during the last three years have allowed local programs to make significant increases in program quality. These increases are directed at much-needed improvements in facilities, hiring of family workers, and more competitive salaries and benefits in order to attract and retain quality staff. Through more effective monitoring and technical assistance, we are assuring that all Head Start programs provide good quality services and we are replacing programs that cannot. One important aspect of the quality improvement process has been the revision and updating of the Head Start Performance Standards and Measures, important yardsticks for evaluating the effectiveness of local programs.

The Head Start Program Performance Standards were developed in the 1970's as a guide for day-to-day program operations. These standards cover the areas of health, social services, parent involvement and education for children ages three to five. As directed by the 1994 Head Start reauthorization act, HHS is engaged in revising the standards to better support quality. We anticipate publishing a proposed regulation for comment this spring. The revised standards include two new sections: Family and Community Partnerships, and Program Design and Management. The updated standards also incorporate services for pregnant women, infants and toddlers to support the Early Head Start program. HHS has engaged in

extensive consultation to revise these standards, convening over 70 focus groups and receiving the input of over 2,000 people and national organizations. Head Start is also in the process of developing Program Performance Measures to assess the quality and effectiveness of the program through outcomes and indicators. These measures are intended to provide a process for continuous improvement over time.

Another recent advance involves services to young children. In FY 1995, the Early Head Start program was established in recognition of the mounting evidence that the earliest years are extremely important to children's growth and development. Serving low-income children under the age of three and pregnant women, Early Head Start funds in FY 1997 will be equal to 4 percent of the total Head Start budget or $159.3 million. In FY 1997, these funds will support an estimated enrollment level of 25,600 children and their families, a 41 percent increase in enrollment since FY 1995. Children and families enrolled in Early Head Start will receive early, continuous, intensive and comprehensive child development and family support services.

Child Care and Development Block Grant

The FY 1997 budget request for the Child Care and Development Block Grant (CCDBG) is $1.049 billion. This request is a component of the Administration's continued commitment to promoting family self-sufficiency by helping States fund child care services for over 70,000 additional children from low-income working families.

The availability of quality child care for low-income families is critical to maintain economic self-sufficiency and to promote healthy child development. Over one million children could require child care assistance by the year 2000 in order to meet the work requirements put forth in most major welfare proposals. Many low-income working families spend up to 25 percent of their income on child care. The Child Care and Development Block Grant provides child care funds to States for low-income families with a parent who is working or attending a training or educational program or children in need of protective services. Over 750,000 children currently receive program services, but waiting lists for assistance still exist nationwide.

CCDBG also supports activities to improve the quality and availability of child care across the nation. Funds are used by States to support consumer education, provider training, licensing and monitoring, and outreach to build the supply of infant care, school age care, care for families working non-traditional hours, and care for children with special needs. In an effort to further improve service, ACF has streamlined operations and recently launched a national campaign, "Healthy Child Care America," to promote sound health and early childhood development practices in child care settings. CCDBG funds provide the foundation for safe and healthy care so critical to optimal child development.

Low Income Home Energy Assistance Program (LIHEAP)

The FY 1997 budget request for LIHEAP includes $1 billion in regular appropriations and $300 million in emergency funding. In addition, ACF is requesting a $1 billion advance appropriation for FY 1998.

The LIHEAP program provides grants to States, territories, tribes and tribal organizations to assist low-income households in meeting home energy costs. Flexible program requirements allow States to target assistance to the areas with the greatest needs, support weatherization efforts, and leverage additional energy dollars from non-Federal sources. To date in FY 1996, $900 million has been made available, primarily for heating and crisis assistance.

Child Welfare/Child Abuse

In FY 1997, ACF is requesting $419 million in discretionary funding for a range of programs that help States and local communities to protect children by strengthening families and preventing abuse; intervening when families are in crisis; and when necessary, making placement decisions to ensure children's safety. A total of $50.6 million will be used to fund Community-Based Resource Centers which support statewide networks of local child abuse and neglect prevention and family resource programs. In FY 1997, ACF will also consolidate research and training programs into the Child Welfare Innovative Programs account, totaling $39.1 million, to allow greater flexibility in funding promising initiatives and to disseminate knowledge on what works best across the spectrum of child welfare services.

In 1993, States received reports on nearly three million children who were alleged victims of child abuse and neglect, reflecting a 25 percent increase in the rate of children reported since 1988. The U.S. Advisory Board on Child Abuse and Neglect estimated that 2,000 of these children die each year as a result of abuse or neglect. As demands on the child welfare system to protect abused and neglected children increase and State and local agencies are overburdened, ACF has dedicated funding to promote children's healthy development by preventing and treating the effects of child abuse and neglect.

Teen Pregnancy Prevention

Teen pregnancy rates remain alarmingly high in the U.S. President Clinton, recognizing the impact of this tragedy, has referred to teen pregnancy as one of our most serious social problems. In an effort to help local communities further develop effective prevention strategies, HHS will launch a $30 million collaborative Teen Pregnancy Prevention Initiative in FY 1997. Demonstration grants to combat teen pregnancy will be made available to selected cities with relatively high teen pregnancy rates. Funds will be targeted to communities that have demonstrated a commitment to community problem solving and developed an appropriate infrastructure for implementing proposed strategies. Grant funds will be available to initiate, expand, or enhance comprehensive prevention strategies which utilize social, economic, and educational approaches to reaching at-risk teens. Drawing upon

strong community and family support for this initiative together we can help to ensure safe passages for our Nation's adolescents.

Refugee Resettlement

The FY 1997 budget request for the Refugee and Entrant Assistance program is $381.5 million, based on a projected refugee ceiling of 75,000 and an additional 15,000 Cuban entrant arrivals. In order to be designated as refugees, people must have a well-founded fear of persecution in their country of origin because of race, religion, nationality, membership in a particular social group, or political opinion. Entrant arrivals are a result of the U.S./Cuban Migration Agreements which sought to end mass illegal immigration from Cuba. Over 22,000 Cuban entrants arrived in the United States in FY 1995 while nearly 100,000 refugees and Amerasians arrived. In January 1996, the last of the 30,500 Cubans and 500 Haitians previously detained at Guantanamo Bay were admitted to the U.S.

This funding level will provide States the capacity to provide eight months of refugee cash and medical assistance, as well as reimbursement for the care of refugee unaccompanied minors. This request will also support Preventive Health, Targeted Assistance and Social Services programs administered by public and private non-profit agencies. These programs help refugees become self-supporting and socially adjusted upon arrival in the U.S.

Community Services Block Grant

The Community Services Block Grant Program provides States, territories, and Indian Tribes with a flexible source of funding to ameliorate the causes of poverty. In FY 1997, ACF is requesting $389.6 million for this program. Grant funds will be used by a network of local agencies including community action agencies, tribes, and tribal organizations to provide a range of services and activities to assist low-income individuals. ACF is not seeking funding for other discretionary Community Services programs. This decision reflects the concerns of Congress to reduce the number of discretionary grant programs and the Administration's intention to develop more comprehensive programs.

Developmental Disabilities

In FY 1997, ACF is requesting $121.9 million to support programs that protect the rights and promote the self-sufficiency of Americans with developmental disabilities and their families. The Administration for Developmental Disabilities programs serve nearly four million Americans with severe, chronic disabilities attributable to mental and/or physical impairment, which are manifested before age 22, are likely to continue indefinitely, and result in substantial limitations in major life activity. Funds for this program help State governments, local communities, and the private sector to integrate disabled individuals socially and economically into mainstream society through the development of Statewide coordinated systems, the establishment of protection and advocacy systems to assist individuals in exercising their human and legal rights, university affiliated programs to disseminate

information, and special projects which focus on the most pressing national issues affecting people with developmental disabilities and their families.

Violence Against Women Programs

In his State of the Union address, President Clinton challenged the citizens of this nation, stating, "I call on American men and women in families to give greater respect to one another. We must end the deadly scourge of domestic violence in our country." In FY 1997, ACF is requesting $15 million in grants for battered women's shelters for a total Family Violence program level of $47.6 million. This funding helps States, territories, and tribes provide shelter services to victims of family violence and their children and for related services, such as alcohol and substance abuse prevention and family violence prevention counseling.

The budget also includes $400,000 for the Domestic Violence Hotline (1-800-799-SAFE). This national, 24-hour, toll-free hotline was first funded in FY 1995 and began providing crisis assistance, counseling, and local shelter referrals across the country on February 21, 1996. Hotline counselors are also available for non-English speakers and the hearing impaired.

ACF Entitlement Programs

For three years, the Administration and the Department have worked aggressively to overhaul the nation's welfare system both incrementally through State waivers, and comprehensively, through fundamental legislative reforms. We have granted waivers to nearly 40 States, to provide them with the freedom to move people out of welfare and into jobs. As a result, nearly ten million welfare recipients are in households where the adults are being required to work, and to take more responsibility for their families and their future. These incremental successes are encouraging, but they are only a beginning. Building upon the principles of work and responsibility, we are committed to working with the Congress to enact a bipartisan welfare reform bill.

The President’s FY 1997 budget includes a revised proposal to reform the welfare system. The new plan saves $40 billion over seven years while promoting sweeping work-based reforms and protecting children. The key elements of the President’s welfare reform proposal are:

- A time-limited conditional entitlement in return for work: AFDC would be eliminated and replaced with the Temporary Employment Assistance (TEA). The TEA program would provide cash benefits to eligible families with needy children. As soon as they join the rolls, beneficiaries would have to develop and sign a personal responsibility contract with their welfare office. Within two years, able-bodied parents would have to work or lose their benefits. Cash assistance would be limited to five years. In order to protect vulnerable families, exemptions from the time limit would be allowed for hardship cases and vouchers would be provided for children whose parents reach the time limit.

- Child care to reward work over welfare: Child care is vital to moving people off welfare and helping them stay off. The President's budget contains $3.8 billion for child care programs to help low-income parents gain the skills to hold a job, or look for one. Child care funds also would help parents avoid welfare in the first place.

- Work programs to help recipients move into the labor market: The President's welfare reform proposal establishes tough work requirements by replacing the JOBS program with the Work First program. The plan would provide a block grant to States to cover the cost of providing job placement, job training and other employment services, administering the cash benefit program, and delivering emergency assistance. It provides States with increased flexibility to design and operate work programs that best meet the needs of their communities. States would receive financial incentives for moving families from welfare to work.

- Protection during economic downturns: The President's plan maintains a flexible funding structure that adjusts to changing economic circumstances. In a recession, State revenues fall even as welfare caseloads rise because more jobless families seek public assistance. Without a funding structure that can adjust to caseload changes, a recession could render many States unable to keep paying welfare benefits and still meet the tough work requirements of any real reform. While providing this protection for States, the President's plan also requires States to maintain their stake in moving people from welfare to work and holds States accountable for making welfare reform a success.

- Tougher child support enforcement: The President's plan includes new child support enforcement measures that emphasize parental responsibility including: revoking driver and professional licenses for parents who refuse to pay child support, improving interstate laws to find such parents, and strengthening the tools to establish paternity so that both parents take full responsibility for their children.

Now, we must encourage the Congress to do its part to enact changes that will encourage work, protect families, and reduce spending. Until then, we will continue the process of welfare reform through waivers, one State at a time.

The following pages summarize projected spending for AFDC and related programs under current law in the event that comprehensive welfare reform is not enacted prior to FY 1997.

Job Opportunities and Basic Skills Training

A total of $1 billion would be required under current law in FY 1997 to support the Job Opportunities and Basic Skills Training (JOBS) program, a key element of current efforts to help welfare recipients achieve self-sufficiency. The program gives States flexibility to provide training and work opportunities geared to their particular AFDC recipients' needs.

Currently, over 600,000 people are active in JOBS programs each month. States have wide flexibility in structuring the mix of programs they offer to recipients. Programs must include: educational activities (e.g., high school or equivalent level, basic and remedial education);

job skills training; job readiness training activities; and job development and placement assistance. States must also include at least two of the following components in their programs: job search programs; on-the-job training; work supplementation programs; and community work experience programs.

Aid to Families with Dependent Children

The Aid to Families with Dependent Children (AFDC) program provides funding to States for cash assistance to low-income families with dependent children who have been deprived of parental financial support due to the death, disability, unemployment or continued absence of a parent. Reductions in caseload over the last year of approximately 6.6 percent have resulted in decreased spending in FY 1996 for this program. Recent estimates suggest that budget authority for benefit payments in FY 1996 will be 8 percent below comparable spending in FY 1995.

In addition to AFDC benefits, States also have the option of operating the AFDC Emergency Assistance program. This program provides financial assistance, medical, and/or social services to needy families with children to meet temporary, emergency needs. Budget authority of $1.9 billion is requested for FY 1997, including amounts to pay for claims from prior years. State claims under the Emergency Assistance program have increased by over 1,000 percent since 1991 as more States have begun to participate, and as States have attempted to claim Federal reimbursement for a wider range of activities, including various types of child protective services and medical emergencies for children not receiving Medicaid, and to cover a broader range of recipients. In FY 1996, the Administration for Children and Families issued policy clarification to States that prohibited the costs of juvenile justice programs from being funded as Emergency Assistance.

AFDC Child Care (Title IV-A)

In FY 1997, $1.45 billion would be required under current law for three child care programs: child care for JOBS participants, former AFDC recipients who work, and those at risk of becoming AFDC recipients. More than half of these funds, $880 million, will support current AFDC recipients' efforts to become self-sufficient by paying for child care that these recipients need to participate in education, training, and work activities. As recipients become self-sufficient and leave the AFDC rolls due to increased employment income, States will provide recipients with up to 12 months of child care to ease the transition from welfare to work. A total of $268 million is requested for this Transitional Child Care program in FY 1997. Finally, the At-Risk (non-AFDC) Child Care program provides child care assistance to families at risk of becoming AFDC recipients. The FY 1997 request for this program totals $300 million.

Child Support Enforcement

The Child Support Enforcement (CSE) program is a joint Federal, State and local partnership that seeks to locate noncustodial parents, establish paternity, and set and enforce support

orders. Costs of these activities are jointly financed by the Federal Government (66 percent) and the States (34 percent). In FY 1997 it is estimated that a total of $2.1 billion will be expended in order to collect over $12.5 billion in payments.

The first $50 of currently-due support collected on behalf of an AFDC family in a month is given to that family, while the balance can be used by Federal, State and local governments to offset their costs of assisting these families. From the Federal share, States also receive an incentive payment based on program efficiency and the amount of their collections. The remaining Federal share is available to offset Federal AFDC benefit costs. Collections made on behalf of non-AFDC families are paid directly to these families. For non-AFDC families with low incomes, receipt of child support assists them in remaining off the welfare rolls.

Since the creation of the child support enforcement program, total child support collections have increased annually. In recent years, States have increased collections by using approaches such as income withholding, offset of income tax refunds, support guidelines and closer links to credit bureaus. In FY 1997, $12.5 billion in child support collections are projected to be distributed to families and shared by governments, an 8 percent gain in collections over FY 1996. In FY 1996, this represents a total return of almost $4 for every dollar invested in the administration of the program. Since the inception of the program in FY 1975, a total of $83 billion has been collected.

The Office of Child Support Enforcement (OCSE) has a new initiative to promote dramatically improved performance, service quality and public satisfaction with the child support enforcement program. As a pilot project under the Government Performance and Results Act (GPRA), HHS has begun strengthening partnerships with State child support agencies. OCSE has approved 33 applications from State and local governments to implement innovative approaches in their programs. Examples include new efforts to improve access to medical insurance, encourage welfare mothers' cooperation in identifying and locating alleged fathers, and provide employment counseling to noncustodial parents.

CHILD SUPPORT ENFORCEMENT COLLECTIONS AND COSTS

(Dollars in millions)
(outlays)

	1995 Actual	1996 Policy	1997 Request	Estimate +/- Policy
Total Collections Distributed to:				
AFDC/FC Families	$476	$509	$544	+$35
Non-AFDC Families	8,018	8,730	9,446	+716
AFDC program	2,143	2,278	2,437	+159
FC program	22	23	24	+1
Total	$10,659	$11,540	$12,451	+$911
Distributed to AFDC Program:				
Net Federal Share	$822	$853	$907	+$54
State Share	1,321	1,425	1,530	+105
Total	$2,143	$2,278	$2,437	+$159
Administrative Costs:				
Federal Share	$1,993	$2,026	$2,109	+$83
State Share	918	976	1,055	+79
Costs	$2,911	$3,002	$3,164	+$162
Program Savings and Costs: (Collections minus Costs)				
Federal Costs	$1,171	$1,173	$1,202	+$29
State Savings	(403)	(449)	(475)	+(26)
Net Costs	$768	$724	$727	+$3

Foster Care, Adoption Assistance and Independent Living

A total of $4.4 billion in budget authority is requested in FY 1997 for the Foster Care, Adoption Assistance and Independent Living programs. Of this request, $3.8 billion is requested for the Foster Care program, which will provide payments on behalf of almost 285,000 children each month. This request will also fund State administration, including child welfare case management systems, training, and State data systems. In FY 1997, under the Adoption Assistance program, ACF is requesting $568 million to provide subsidy payments to families who have adopted special needs children. Payments are made on behalf of adopted children up to their 18th birthday and this level of funding will support approximately 131,000 children each month. The Independent Living Program will receive $70 million to continue services to help teenagers under State supervision make the transition to living on their own.

Family Preservation and Support

For FY 1997, $240 million will be made available to States and eligible tribes as part of a continuing five-year funding plan started in FY 1994 to strengthen family preservation and support services. These services help State protection welfare agencies and eligible Indian tribes establish and operate integrated, preventive family preservation services and community-based family support services for families at risk or in crisis. Family preservation services are activities that help families alleviate crises that might lead to out-of-home placements of children because of abuse or neglect. Family support services, often provided by community-based organizations, are voluntary, preventive activities to help families nurture their children. These activities help to prevent the unnecessary separation of children from their families and improve the quality of care and services.

ACF OVERVIEW

DISCRETIONARY SPENDING

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Head Start	$3,534	$3,631	$3,981	+$350
Child Care Development Block Grant	935	935	1,049	+114
Low Income Home Energy	1,419	1,000	1,000	0
Emergency Funding (non-add) ...	(500)	(300)	(300)	0
Child Welfare:				
Child Welfare Services	292	292	292	0
Child Welfare/Child Abuse.....	127	72	127	+55
Subtotal, Child Welfare	$419	$364	$419	+$55
Refugee & Entrant Assistance	$400	$400	$381	-$19
Targeted Assistance	6	5	0	-5
Community Services Block Grant	458	429	390	-39
Runaway and Homeless Youth	69	57	69	+12
Developmental Disabilities	122	116	122	+6
Violence Against Women Programs	33	38	48	+10
Native Americans.....	38	35	38	+3
Teen Pregnancy Initiative	0	0	30	+30
Social Services Research..	15	0	10	+10
Other ACF	39	8	13	+5
Federal Administration	162	151	160	+9
Total, Program Level/BA.	$7,649	$7,169	$7,710	+$541

* Based on levels of the ninth CR, including an incremental policy adjustment.

ACF OVERVIEW

ENTITLEMENT SPENDING

(Dollars in millions)

	1995 Actual	1996 Estimate*	1997 Estimate*	Increase/ Decrease
Social Service Block Grant	$2,800	$2,800	$2,800	$0
Foster Care/Adoption Assistance.	3,597	4,322	4,445	+123
Family Support & Preservation....	150	225	240	+15
JOBS	1,012	1,000	1,000	0
Family Support Payments (FSP):				
AFDC/Related Assistance**	11,451	10,408	10,780	+372
Emergency Assistance	984	1,687	1,867	+180
Child Care.....	1,152	1,404	1,447	+43
AFDC State Administration.....	1,780	1,679	1,875	+196
Child Support Enforcement Admin	2,124	1,916	2,132	+216
Subtotal, FSP	$17,491	$17,094	$18,101	+$1,007
Subtotal, Entitlements..	$25,050	$25,441	$26,586	+$1,145
Total, ACF BA.....	$32,699	$32,610	$34,296	+$1,686
FTE	1,803	1,803	1,803	0

*.....Funding levels are based on the Administration's most recent estimates of entitlement spending under current law.

**.....AFDC and related assistance is shown net of child support collections.

ADMINISTRATION ON AGING (AoA)

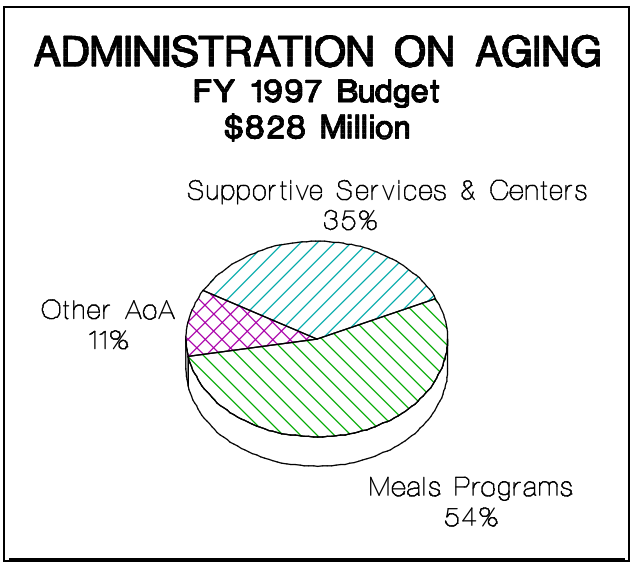
(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Program Level/BA	$876	$828	$828	$0
Outlays	951	776	819	+$43
FTE	177	177	177	0

* Based on levels of the ninth CR, including an incremental policy adjustment.

Summary

The FY 1997 budget for the Administration on Aging (AoA) provides $828 million for programs aimed at improving older Americans' quality of life. In addition, the budget reflects the Administration's desire to consolidate, in AoA, the management and oversight of programs that serve the elderly. The Department of Agriculture will transfer administration of their Nutrition Programs for the Elderly to AoA, and the Department of Labor will transfer administration of their Older Workers program to AoA. The programs funded by AoA help senior citizens remain independent and productive.



AoA serves older persons and their families through the administration of the Older Americans Act and aging-related research and educational projects. As the focal point in the Federal Government for serving older persons, AoA works to advance the dignity and independence of the nations' elderly. By the year 2030, the number of people aged 60 and older will increase to 89 million, while those 85 and older will increase to almost nine million. AoA recognizes the need to address these demographic changes, and is striving to prepare both older and younger Americans for their aging.

Nutrition Programs

For FY 1997, AoA requests $451.2 million for Nutrition Programs. Over 240 million meals

were served last year through the Aging Network--about half of meal recipients are low-income elders and about 16 percent of recipients are members of minority groups. Recipients of home-delivered meals are among the most vulnerable elderly in the community, with 73 percent considered to be frail and disabled and 53 percent being low-income. Between 1980-1993, the number of home-delivered meals increased by 180 percent, reflecting not only a growing elderly population but also an elderly population composed of increasingly older and more frail individuals. Moreover, the volunteers who deliver the meals often serve as informal gatekeepers, assessing if recipients have other needs and linking them to additional services.

Congregate nutrition services provide a cooked, ready, nutritious meal to seniors in a group setting. Participation in a group setting reduces isolation and encourages continued physical and mental functioning. The Older Americans Act directs that priority be given to those who are in greatest economic and social need, with particular attention to low-income, minority older persons.

Supportive Services

The FY 1997 budget request reflects AoA's commitment to ensure that older Americans have an independent, productive, healthy and secure life. Supportive services represent the cornerstone of the comprehensive and coordinated system of home and community-based services that address the needs of the elderly. The FY 1997 budget provides funding for a network of 57 State units, 228 Indian tribal organizations, 670 Area Agencies on Aging, approximately 6,000 senior centers and more than 27,000 service providers throughout the country. Supportive services and centers have provided over 40 million rides, over 12 million responses for information and referrals, nearly 10 million personal care services to elderly in need, and approximately one million legal counseling sessions.

Long-Term Care

One of the great challenges confronting America's families is care for relatives who are elderly or disabled. This challenge is often accompanied by fear as older and disabled persons face their own aging or increased disabilities. The FY 1997 request reflects a commitment to addressing these family needs as it shapes a long-term care system for the future.

The FY 1997 budget request provides $9.2 million for in-home services for the frail elderly. The rapid growth of the age 85 and over population brings new demands for care because of limited mobility, increasing disability, more elderly living alone and the higher risk of poverty. By supporting the provision of services to frail older individuals, the program increases the access of vulnerable older individuals to needed assistance and helps them avoid institutionalization.

The Long-Term Ombudsman Program will be funded at $4.5 million in FY 1997. This request underscores the crucial role ombudsmen play in the long-term care system and the

useful assistance they provide to residents and their families related to their care. Ombudsman programs in all States, Puerto Rico and the District of Columbia serve the Nation's 1.5 million nursing home residents, who are the most frail and vulnerable group in the long-term care system.

Additional activities funded through AoA include basic and applied research on the chronic illnesses that contribute to disability and efforts to improve the efficiency and effectiveness of community-based long-term care systems. The challenge here is to enable States and local governments to design and build on innovative models of integrated care and service delivery and to make their long-term care systems more customer-oriented in FY 1997.

Proposed Transfers

AoA's reauthorization legislation pending before Congress proposes to transfer $150 million from the USDA's Nutrition Program for the Elderly, and replace it with the Nutrition Services Incentive Program under Title III-C of the Older Americans Act. The Nutrition Services Incentive Program would be administered by AoA; however, the funds would continue to be appropriated to the Department of Agriculture.

The reauthorization also proposes to transfer the Department of Labor's Community Service Employment for Older Americans program (Title V) to AoA. This proposal would ensure national responsiveness to local community needs. It would allow greater flexibility to consolidate, coordinate, link and expand limited resources to enhance community service and employment and training for low-income seniors. The proposed transfer would amount to $350 million.

AoA OVERVIEW

(Dollars in millions)

	1995 Actual	1996 Policy/1	1997 Request	Request +/-Policy
Current Law:				
Supportive Services	$306	$295	$295	$0
Meals:				
Congregate Meals	376	357	357	0
Home-Delivered	94	94	94	0
Subtotal, Meals	$470	$451	$451	$0
In-home Services-Frail Elderly.	$9	$9	$9	$0
Indian/Tribal Grants	17	16	16	0
Preventive Health	17	17	17	0
Research, Training and Demos.	26	12	12	0
Ombudsman Services.	5	5	5	0
Prevention of Elder Abuse .	5	5	5	0
Pension Counseling.	2	2	2	0
White House Conference	3	0	0	0
Federal Administration.	16	16	16	0
Federal Council on Aging	0.1	0.2	0.2	0
Subtotal, BA	$876	$828	$828	$0
Proposed Transfers:/2				
Department of Ag./NPE	*($150)*	*($150)*	*($150)*	*$0*
Department of Labor	*(396)*	*(350)*	*(350)*	*0*
Subtotal, Proposed Transfers	*($546)*	*($500)*	*($500)*	*$0*
Total, BA	$876	$828	$828	$0
FTE	177	177	177	0

1/ Based on levels of the ninth CR, including an incremental policy adjustment.

2/ Proposed Bill language transfers $150 million from the Department of Ag. Nutrition Programs for the Elderly (NPE) and $350 million from the Department of Labor Community Work Program for the Elderly to be administered by AoA. 1995 Actual and 1996 Policy levels for these programs are provided for comparison only.

DEPARTMENTAL MANAGEMENT

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/- Policy
Program Level	$214	$192	$198	+$6
Budget Authority	188	172	178	+6
Outlays	256	219	167	-52
FTE	1,544	1,544	1,544	0

* Based on levels of the ninth CR.

Summary

The Departmental Management (DM) budget includes requests for five separate appropriations--General Departmental Management, Office for Civil Rights, Policy Research, Office of Consumer Affairs, and the Public Health and Social Service Emergency Funds--that fund activities which provide leadership, policy, legal, and administrative guidance to HHS components; carry out the Department's civil rights and nondiscrimination enforcement programs; present consumer needs and viewpoints in the Federal Government; and support research to develop policy initiatives and improve existing HHS programs. DM also incorporates the activities of the former Office of the Assistant Secretary for Health (OASH), including adolescent family life, disease prevention and health promotion, physical fitness and sports, minority health, research integrity, women's health, HIV/AIDS policy, and emergency preparedness. The operation and maintenance of central and common administrative, fiscal, and personnel support services have been centralized in the Program Support Center, a newly created HHS Operating Division (OPDIV).

General Departmental Management

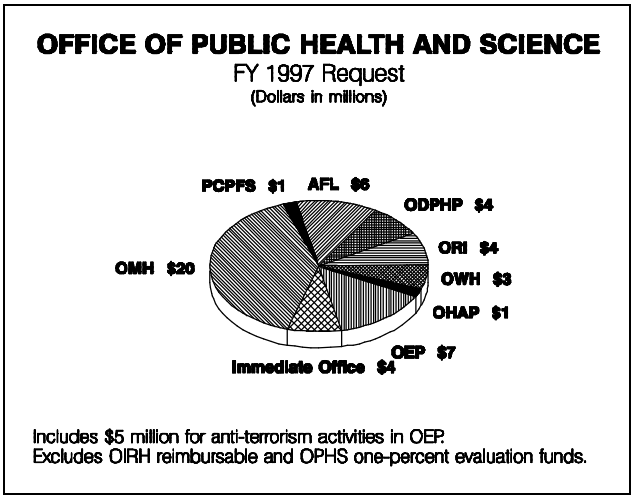
The FY 1997 budget request provides a program level of $165 million for General Departmental Management (GDM), including an appropriation of $145 million and intra-agency transfers of $20 million in one-percent evaluation funds. GDM supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department through nine Staff Divisions (STAFFDIVs): the Immediate Office of the Secretary, the Offices of Public Affairs, Legislation, Planning and Evaluation, Management and Budget, Intergovernmental Affairs, General Counsel, and Public Health and Science, and the Departmental Appeals Board. The operations of the Assistant Secretary for Personnel

Management and the Assistant Secretary for Management and Budget were merged in FY 1996.

As part of the Department's reinvention and streamlining processes, the Office of the Assistant Secretary for Health was merged with the Office of the Secretary, eliminating an entire management layer. The new Office of Public Health and Science (OPHS), headed by the Assistant Secretary for Health (ASH), and the Public Health Service OPDIVs report directly to the Secretary. The ASH functions as senior advisor for public health and science to the Secretary and provides senior professional leadership in the Department on population-based public health and clinical preventive services. The ASH also provides direction to the following OPHS program offices:

- Adolescent Family Life Program - supports grants which encourage adolescents to delay sexual behavior, provides service to pregnant and parenting teens, and researches adolescent pregnancy issues. The request will support the same number of grants (18) as in FY 1996.

- Office of Disease Prevention and Health Promotion - coordinates health promotion and disease prevention activities among the Department's Operating Divisions, other Federal Departments, and the private and voluntary sectors.



- President's Council for Physical Fitness and Sports - promotes and encourages physical activity/fitness and sports participation for Americans of all ages and abilities.

- Office of Minority Health - coordinates disease prevention, health promotion, and health service delivery for disadvantaged and minority individuals and supports research on minority health topics, the goal of which is to improve the health status of racial and ethnic minority populations in the United States which continues to lag behind the health status of the American population as a whole.

- Office of Research Integrity - oversees and directs the research integrity efforts of the Public Health Service, with the exception of the regulatory research activities of the Food and Drug Administration.

- Office on Women's Health - serves as the Department's focal point for the improvement and protection of women's health by redressing inequities in the conduct of research, health services, prevention, and public and health professional education and training on women's health issues.

- Office of Emergency Preparedness - manages and coordinates the health and medical and health-related social services that are provided by the Federal Government to victims of catastrophic disasters through the Federal Response Plan Emergency Support Function (ESF) #8. Under ESF #8, HHS coordinates the support of 12 Federal agencies in the preparedness for, response to, and recovery from natural and man-made disasters.

  The Department is the lead Federal agency for the management of the response to the health and medical consequences of a major terrorist event. The Office of Emergency Preparedness has been tasked by the National Security Council to assess and remedy any shortfalls in the health and medical consequence response capabilities necessary in the event of a terrorist use of a weapon of mass destruction, be it chemical, biological or nuclear. The FY 1997 budget request includes anti-terrorism funding of $5 million to begin to ensure an effective and coordinated local, State, and Federal Government response to a terrorist incident.

- Office of HIV/AIDS Policy - provides professional expertise to the Secretary and the Assistant Secretary for Health in the areas of HIV/AIDS prevention, treatment and rehabilitation and leadership in policy development and program coordination related to the Department's response to the HIV epidemic in the United States.

- Office of International and Refugee Health - serves as the HHS focal point for policy guidance, planning, evaluation, and program coordination related to international and refugee health affairs, funded through reimbursable agreements with the Department of State, United States Agency for International Development, and international health organizations (WHO and UNICEF).

Office for Civil Rights

The FY 1997 budget request for the Office for Civil Rights (OCR) is $22 million, the same as the FY 1995 level and an increase of $3 million over the FY 1996 operating level. OCR is responsible for enforcing nine major civil rights statutes that prohibit discrimination in Federally-assisted health care and social services programs. These statutes cover nondiscrimination on the basis of race, national origin, disability, age, and in limited instances, sex and religion. In addition, OCR is responsible for coordinating the implementation of the Section 504 regulation that prohibits discrimination against persons with disabilities in programs and activities conducted by HHS. OCR enforces nondiscrimination requirements by processing and resolving discrimination complaints, conducting reviews and investigations, monitoring corrective action plans, and carrying out voluntary compliance, outreach and technical assistance activities. OCR has made significant progress in addressing issues such as race discrimination in access to health care and discrimination against persons with disabilities. In FY 1995, OCR completed 5,655 discrimination complaint and review cases, with 40 to 50 percent of the cases resulting in changes in policies and practices.

This budget request reflects the continuation of the implementation of OCR's strategic plan. The plan has resulted in significant reengineering of OCR's investigative and compliance

processes through redesign and streamlining. The plan calls for expanded use of innovative partnerships both within HHS and at the State and local levels to ensure civil rights compliance. As a result of strategic plan initiatives, review and complaint investigation production is projected to increase by more than 45 percent. In addition, the FY 1997 budget request includes funds to support outreach and other compliance initiatives that seek new ways of preventing civil rights problems and addressing potential discrimination in HHS programs.

Policy Research

The FY 1997 budget request includes $9 million for Policy Research (PR) to support research on policy issues of national significance. Priority issues that PR will examine are those related to welfare reform, health care, family support and independence, poverty, at-risk children and youth, aging and disability, science policy, and improved access to health care and support services.

U.S. Office of Consumer Affairs

The FY 1997 budget request for the U.S. Office of Consumer Affairs is $2 million. These funds will support presentation of consumer viewpoints within the Executive Branch especially related to fraud, telecommunications and privacy issues; publication and distribution of the Consumer's Resource Handbook and other consumer information materials; and operation of the National Consumer Helpline, a Federal clearinghouse for consumer complaint handling, information and referral.

DEPARTMENTAL MANAGEMENT SUMMARY

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/- Policy
General Departmental Management	$181	$162	$165	+$3
Office for Civil Rights	22	19	22	+3
Policy Research	9	9	9	0
U.S. Office of Consumer Affairs.....	2	2	2	0
Subtotal, Program Level	$214	$192	$198	+$6
Less: Intra-agency Transfers	-26	-20	-20	0
Total, BA	$188	$172	$178	+$6
FTE	1,544	1,544	1,544	0

* Based on levels of the ninth CR.

OFFICE OF INSPECTOR GENERAL

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/- Policy
Program Level	$79	$74	$75	+$1
Budget Authority	79	74	75	+1
Outlays	89	67	75	+7
FTE	927	927	927	0

* Based on levels of the ninth CR.

Summary

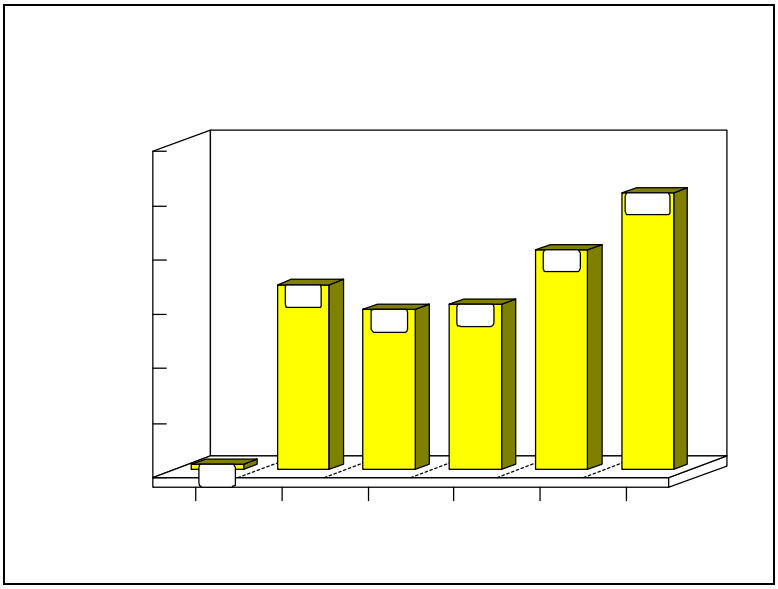
For FY 1997, the Office of Inspector General (OIG) requests $75 million, an increase of $1 million above the FY 1996 level. OIG is charged with conducting and supervising audits and investigations relating to programs and operations of HHS; providing leadership and coordination for, and recommending policies and corrective actions concerning, activities designed to promote economy and efficiency in the administration of the Department's programs; and preventing and detecting fraud and abuse in HHS' programs and operations.

In FY 1997, OIG will focus its resources in the following areas: reviewing departmental efforts to improve children's welfare and child support enforcement collection initiatives; evaluating providers and services in the Medicare and Medicaid programs; ensuring the effectiveness of the public health delivery programs; and auditing management control systems and financial operations. All of these reviews will assist HHS program managers to improve the health and welfare of program beneficiaries.

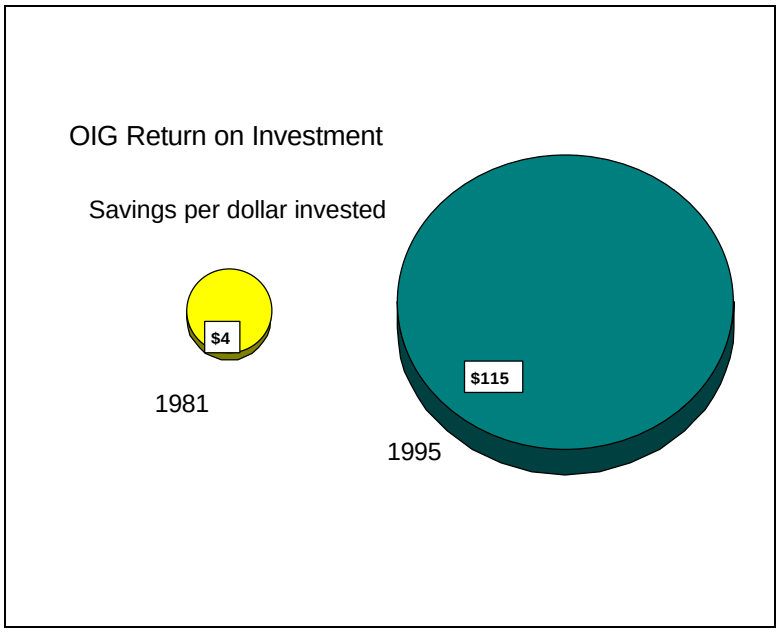
OIG resources will also be devoted to the final phase of Operation Restore Trust. Under this project, OIG, HCFA and AoA will continue their interdisciplinary teams of Federal, State, and private sector representatives targeting health care fraud and abuse in California, Florida, New York, Texas and Illinois--these five States account for more than a third of all Medicare beneficiaries and nearly 40 percent of Medicaid recipients. The project team is focusing on the three fastest growing areas of Medicare expenditures: nursing facilities, home health, and durable medical equipment.

The Medicare Anti-fraud and Abuse Program (MAAP) is a proposed new initiative to restore trust and accountability to Medicare. This program would build on the proven effective aspects of Operation Restore Trust, enhance general Medicare fraud protection activities, allow OIG to pursue innovative anti-fraud initiatives, enhance data systems to assess trends

and identify possible fraud and abuse, and expand OIG resources by retraining and adding staff to those parts of the country where fraud schemes are unfolding. Should this legislation be enacted, an additional $54 million will be added to supplement OIG's current effort.



In FY 1995, OIG asserts that its activities resulted in over $10.2 billion in settlements, fines, restitutions, receivables and savings to the Federal Government. The OIG asserts that the return on investment increased from $160,000 per OIG FTE in 1981 to $9.7 million in 1995, and from $4 in savings for every OIG budget dollar spent in 1981 to $115 in savings for every OIG budget dollar spent in 1995. During the same time period, successful judicial prosecutions rose from 165 in FY 1981 to 620 in FY 1995. Administrative sanctions against individuals or entities that defrauded or abused HHS programs and/or beneficiaries also rose from 39 in FY 1981 to 1,563 in FY 1995.



OIG is continuing to streamline its operations and management structure to minimize costs and ensure that the greatest portion of its resources are concentrated on investigations, audits, and inspections.

OIG is also reinventing its processes and exploring creative ways to effectively deploy its resources to aggressively combat fraud, abuse, and waste in the Department's programs, including:

- Establishing partnerships with State auditors under which OIG provides States with audit methodologies for their use in conducting audits of HHS health care programs. In addition to recovering taxpayer dollars, these partnerships will also result in program improvements and a reduction in the cost of providing needed services to Medicaid and other recipients.

- Conducting joint investigations with other Federal law enforcement agencies, including the Secret Service, the Federal Bureau of Investigation (FBI), the Internal Revenue Service, the Postal Inspection Service, State governments, other Inspector General offices, and the HHS OPDIVs.

- As part of Operation Restore Trust, a "voluntary disclosure" program is being piloted that encourages corporate health care providers to disclose potential instances of fraud and abuse that the providers themselves have discovered within their corporations.

OFFICE OF INSPECTOR GENERAL SUMMARY

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/- Policy
Total, BA	$79	$74	$75	+1
FTE	927	927	927	0

* Based on levels of the ninth CR.

PROGRAM SUPPORT CENTER

HHS Service and Supply Fund

(Dollars in millions)

	1995 Actual	1996 Estimate	1997 Estimate	Increase/ Decrease
Expenses	$225	$232	$237	+$5
FTE	1,261	1,261	1,261	0

Summary

The Program Support Center (PSC) is a new Operating Division formed by combining the administrative activities formerly located in the Office of the Secretary (OS), and funded by the OS Working Capital Fund, with activities from the Office of the Assistant Secretary for Health, and funded by the Public Health Service (PHS) Service and Supply Fund. The formation of the PSC resulted from the Department's REGO II analysis with a goal of further streamlining and minimizing duplication of functions in the provision of cost-effective administrative services to components of the Department and other Federal agencies. Services will be provided in four broad business areas: human resources, financial management, administrative operations, and information technology.

Human Resources Service

The FY 1997 estimated expenses for the Human Resources Service (HRS) are $43 million. HRS provides a full range of personnel management services including payroll management and operations; personnel operations services for civilian and commissioned personnel; common needs training; employee relations and labor relations; and administration of the Board for Corrections of PHS Commissioned Corps Personnel Records.

Financial Management Service

The Financial Management Service (FMS) estimates its expenses at $41 million for FY 1997. FMS supports the financial operations of HHS and other Federal Departments through the provision of payment management services for departmental and other Federal grant and program activities; accounting and fiscal services; debt management services; and the review, negotiation and approval of rates, including indirect cost rates, research patient care rates, and fringe benefit rates.

Administrative Operations Service

The Administrative Operations Service (AOS) supports the administrative management functions within the Department in the areas of property and material management, and support services ranging from telecommunications services and commercial graphics to mail distribution. Included is the operation of a medical supply depot located in Perry Point, Maryland, that provides support to over 1,700 customers on a worldwide basis and is an economical source of supply for all Federal customers. The FY 1997 estimated expenses of $142 million for AOS includes a $5 million increase for the expansion of product lines within the Supply Service Center and increased communication capabilities through the Telecommunication Improvement Project. This project consolidates telephone services under one contract; this collective bargaining results in savings of up to one-third in the rates charged by the telephone company for services to agencies in the Parklawn Complex and the National Institutes of Health campus.

Information Technology Service

The FY 1997 estimated expenses for the Information Technology Service (ITS) is $11 million. The ITS provides automated data processing (ADP) services for HHS and other Federal entities. It provides its customers with various ADP services, resources, technical support and ADP planning assistance. In addition, the ITS develops and operates the Departmental Information Management Exchange System, a nationwide telecommunications network, and serves as the HHS Executive Agent for Department-wide connectivity.

PROGRAM SUPPORT CENTER

ENTITLEMENT SPENDING

Retirement Pay and Medical Benefits for Commissioned Officers

(Dollars in millions)

	1995 Actual	1996 Estimate*	1997 Estimate*	Increase/ Decrease
Retirement Payments	$112	$130	$136	+$6
Survivors' Benefits....	8	9	11	+2
Medical Care.	22	25	26	+1
Military Service Credits.....	2	3	3	0
Total, BA	$144	$167	$176	+$9
Outlays.....	$152	$167	$176	+$9

* Funding levels are based on the Administration's most recent estimates of entitlement spending under current law.

Summary

This appropriation provides for retirement payments to Public Health Service (PHS) Commissioned Officers and payments to survivors of deceased retired officers. This account also funds the provision of medical care to active duty and retired members and to dependents of active duty, retired and deceased members of the PHS Commissioned Corps. In addition, this account includes amounts to be paid to the Social Security Administration for military service credits which are earned by active duty Commissioned Officers for non-wage income.